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of the

AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

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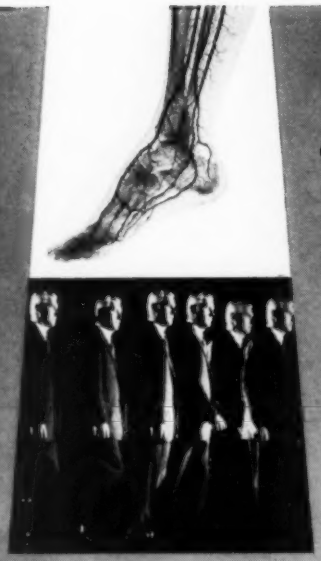
FEBRUARY, 1959



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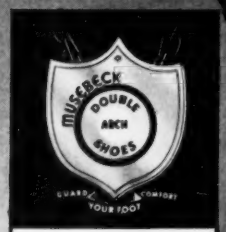

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Published under direction of the Executive Council

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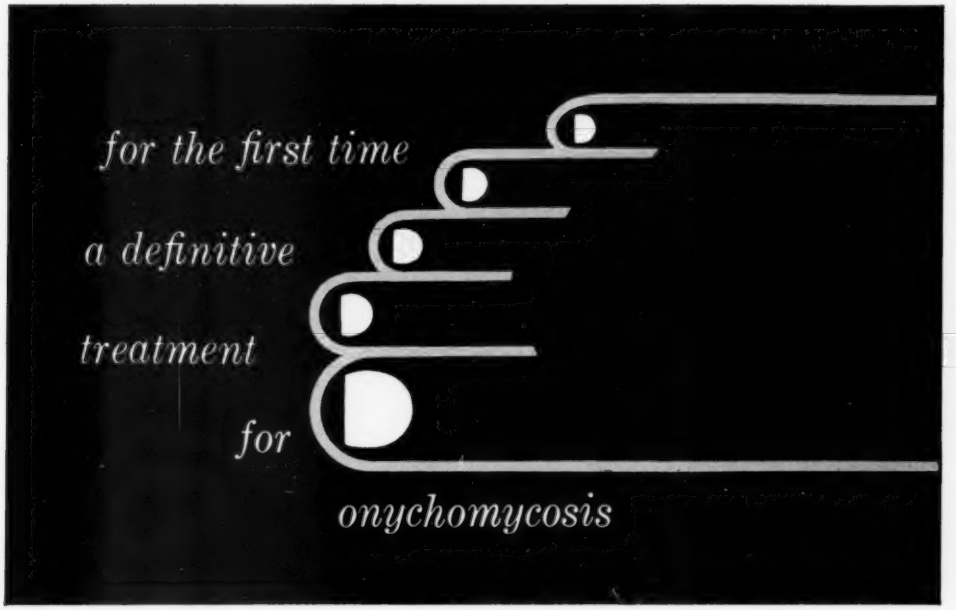

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8:00- 9:00 A.M. Registration
9:00-12:00 A.M. "Body Kinectics"
Dr. Charles M. Hammonds, Brownwood, Texas
12:00- 1:30 P.M. Luncheon
1:30- 5:00 P.M. "Ambulatory Rehabilitation"
Dr. Charles R. Brantingham, Long Beach, Calif.

SATURDAY, MARCH 21, 1959

8:00- 9:00 A.M. Registration
9:00-12:00 A.M. "Functional Foot Orthopedics"
Dr. James W. Hembree, Amarillo, Texas
Dr. James Meade, Plainview, Texas
12:00- 1:30 P.M. Luncheon
1:30- 2:30 P.M. "Malignant Melanoma of the Foot"
E. Richard Harrell, M.D., Ann Arbor, Mich.
2:30- 3:00 P.M. Recess
3:00- 5:00 P.M. "Diagnosis and Treatment in Rheumatology"
E. N. Rottenberg, M.D., Detroit, Mich.

SUNDAY, MARCH 22, 1959

8:00- 9:00 A.M. Registration
9:00-10:00 A.M. "The Services of the A.P.A. and How to Use Them"
Panel A. Rubin G. Guenzler
E. Kaplan L. Thompson
10:00-10:30 A.M. Recess
10:30-12:00 A.M. "Some Everyday Problems Involving the Foot and Ankle"
Philip Lewin, M.D., Chicago, Illinois
12:00- 1:30 P.M. Luncheon
1:30- 2:30 P.M. Films: "Steroids"
"Hospital Chiropody Practice"
Dr. Raymond K. Locke, Englewood, New Jersey
2:30- 3:00 P.M. Recess
3:00- 4:00 P.M. "Human Relations and the Practice Management of Aged Patients"
Dr. J. P. O'Connor, Oshkosh, Wisconsin

TABLE CLINIC PROGRAM

FRIDAY, MARCH 20, 1959

9:00-10:00 A.M. "Treatment of Peripheral Vascular Problems in the Aged Patient"
Dr. Edward Weisman, Chicago, Illinois
2:00- 3:00 P.M. "Tendon Transplant in Correction of Hammer Toe Deformity"
Dr. L. R. McCain, Chicago, Illinois

SATURDAY, MARCH 21, 1959

10:00-11:00 A.M. "Intra-Articular Injection Therapy"
Dr. Richard Katz, Milwaukee, Wisconsin
2:00- 3:00 P.M. "Instrument Sharpening"
Dr. Alvin C. Larson, Hibbing, Minnesota

SUNDAY, MARCH 22, 1959

10:00-11:00 A.M. "New Drugs in the Treatment of Onychomycosis"
Dr. Herbert Bean, Detroit, Michigan
2:00- 3:00 P.M. "Foot Health Examination in the School System"
Dr. Fred G. Broun, Chicago, Illinois

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The Iowa State Board of Chiropody Examiners will meet for examination June 8-10, 1959, at the State Office Building, Des Moines, Iowa. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

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The Kansas State Board of Podiatry Examiners will meet for reciprocity and examination in July, 1959, at Kansas University Medical Center, Kansas City, Kans. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 864 New Brotherhood Bldg., Kansas City, Kansas.

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The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at the State House, Boston, Mass. **Board Secretary:** Dr. Fred T. Reiss, Ritz Carlton Hotel, Boston, Mass.

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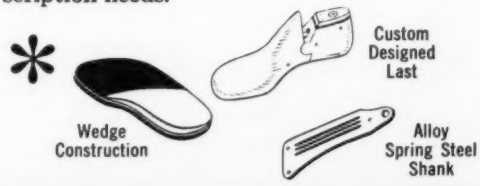

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1. Prentice, H. and Brezak, S.: Jrnl. Amer. Podiatry Assn. 48:191, (May) 1958.
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VOLUME 49 FEBRUARY, 1959 NUMBER 2

TREATMENT OF ONYCHOMYCOSIS WITH ONYCHO-PHYTEX

A Preliminary Report

SHERWIN E. LEVY, D.S.C.*
Los Angeles, Calif.

Onychomycosis may be caused by various species of Trichophyton, Epidermophyton floccosum, Candida albicans, and, rarely, species of Microsporon.[1] Probably the most difficult infections to treat are those due to T. rubrum. Pillsbury, Shelley and Kligman[2] state that ringworm infections of the toenails are incurable. It is their opinion that no topical preparations to date have had any real influence on the course of the infection, any standard fungicidal ointment being about as satisfactory as anything else.

T. rubrum is the etiological agent in the majority of nail fungus infections. Jillson and Piper[3] in a histological study of human infected nails found T. rubrum to be in the deepest or ventral layer and occasionally in the intermediate layer of the nail. Sagher[4] in an earlier study also found T. rubrum to be located in the ventral layer of the nail. From these studies it is easy to see why the use of topical agents has been of little or no value. It is therefore with some hesitancy that we report on the use of another "topical preparation" in the treatment of onychomycosis to add to the Ignatoff[5] and Bleiberg experiences.

Materials and Methods

A total of 32 patients were treated, 29 males and 3 females. Twenty-eight patients had involvement of the toenails and four had involvement of both toe- and fingernails.

It was impossible to determine accurately the duration of infection, the majority of patients stating that the nails had been infected "for years." Likewise, the severity of the infection was somewhat difficult to evaluate; however, an attempt was made, based on the number of nails infected and the extent of the involvement of the individual nail. Thus the severity of infection in each patient was graded as mild, moderate, or severe. Of the 32 cases, 14 were mild, 15 were moderate, and 3 were severely infected.

Onycho-Phytex®[1] is a yellow-brown liquid. Each cc contains: Borotannic complex, 75 mg (derived from tannic acid, 46 mg, and boric acid, 29 mg); salicylic acid, 8 mg; and ethyl alcohol (by vol.), 56%. This medication was applied twice daily.

* Clinical Assistant in Chiropody, University of California School of Medicine, Los Angeles, California; Staff Chiropodist, Veterans Administration Center, Wadsworth Hospital, Los Angeles, California; Staff Chiropodist, Beverly Hills Medical Clinic, Beverly Hills, California.

[1] Wyulit Pharmaceuticals, Inc.

The shortest period of treatment was one month, and the longest was seven months. Patients were examined every one to two weeks while under therapy. No patient was included in the study who did not have a positive culture prior to institution of therapy. Cultures were made on Sabouraud's media. The causative organism was T. rubrum in 19 patients, T. gypseum in 12 patients, and C. albicans in one patient.

Results

Clinical results were graded as follows: No change, 25% improvement, 50% improvement, 75% improvement, and 100% clear. Table I summarizes this data.

TABLE I

Clinical Results	No. of Patients
No change	0
25% improvement	23
50% improvement	6
75% improvement	3
100% clear	0

There were no instances of primary irritation or allergic contact dermatitis. The product was easily applied, and patient-cooperation was good.

Follow-up cultures were done on 11 of the 32 patients. Of the 11 cases, six were from patients with T. rubrum infections, four with T. gypseum infections, and one with C. albicans infection. These cultures were all positive. An additional five patients with T. rubrum infections had positive potassium hydroxide mount preparations for mycelia.

Discussion

All patients with toenail infections also had tinea pedis due to the organism. In addition, all patients with fingernail infections had tinea manum and tinea pedis due to the same organism. No attempt was made to treat the concomitant T. Pedis and/or T. manum. It is probable that the latter provided a constant source of reinfection of the nails.

There was a close correlation between the duration of treatment and the clinical results. The longer the treatment, the better the results. It is our opinion that the results in this study would have been better had the treatment period been longer. In addition, it would seem logical to treat the concomitant T. pedis and T. manum when present. It was, however, our original purpose to only evaluate the effect of Onycho-Phytex in onychomycosis per se.

A cure for onychomycosis is not claimed; however, therapy is so difficult that any modality which appears to be beneficial, and at the same time safe, should be given an adequate trial.

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The man does not live who is more devoted to peace than I am. None who would do more to preserve it. But it may be necessary to put the foot down firmly.—*Speech, New Jersey Assembly, February 21, 1861.*

—*Lincoln*

FOOT ORTHOPEDICS IN THE AGED*

MARVIN J. RUBIN, D.S.C.,F.A.C.F.O.
Hasbrouck Heights, N. J.

Foot orthopedics in the aged is a vast and comprehensive subject which, in its entirety with all its ramifications, would make up the entire practice of chiropody in its relationship to the geriatric. Almost all of the geriatric's problems in his pedal extremity are directly attributed to, or indirectly aggravated by, a mechanical orthopedic problem. This paper will deal basically with the mechanical problems. However, other ramifications must be considered as one cannot divorce the orthopedic problem from the contributing or underlying problems that are peculiar to the aged.

The geriatric is a human being and develops the same problems as other human beings. The manifestations of his orthopedic disability will be the same as that of a younger individual having the same condition. However, there is a difference in the fact that the aged individual is more likely to have other complicating factors. The treatment of the individual will differ in that the geriatric must be treated far more conservatively.

Authorities[1] have stated that the adult foot has taken on its permanent form and to a large extent has lost its ability to alter its architecture. They go on to state that in the adult, little can be accomplished in the way of correcting faults in form and structure, and treatment must be aimed at relieving symptoms. Relief of symptoms is brought about, correcting so far as is possible the faults in balance present which cause ligamental strain and muscular fatigue, and give rise to discomfort and disability.

A careful examination and intelligent evaluation of the faults present should always make it possible to determine what measure should be taken to relieve a painful foot. Once a plan of management has been determined, it must be carried out rigidly if a satisfactory outcome is to be anticipated. Practically every painful and disabling foot disorder can be relieved by proper footwear, proper supports, exercises and such general measures as are required to overcome systemic factors. These statements are made in reference to the adult, but they are far more applicable to the geriatric. Certainly the geriatric foot has lost its ability to alter its architecture. Therefore it will no longer readily respond to Wolf's or Davis' law, and any attempt to force an alteration of the existing architecture can only result in trauma and increased disability.

Treatment therefore must be designed to increase the patient's ability to function with his existing problem, and at the same time reduce the strain and trauma on the basic structures. The underlying problems which must be taken into consideration are the arthritides, peripheral vascular diseases, metabolic diseases and other debilitating diseases. Orthopedic treatment cannot be conducted in a satisfactory manner without proper treatment of these other factors. The management of these problems must be carried out on a systemic as well as a local basis.

Vitamin therapy, particularly of the "B" Complex group, is of value in all of these problems. The salicylates are of proven value in the management of the various arthritides. Where the salicylates are not sufficient, the administration of the newer cortico-steroids is of great value. Many of the local joint disabilities can be satisfactorily relieved by the infiltration of anesthetic solutions. Those joint disabilities which will not respond to anesthetic

*Paper presented at the National Association of Chiropodists' Annual Scientific Session, Chicago, Illinois, August 1957.

solutions should be injected with the cortico-steroids developed for that purpose. There are, at this time, multiple cortico-steroids on the market, both for intra- and peri-articular injection. The satisfactory results attributed to these injections will not be achieved without proper orthopedic management.[2,5] A word of caution: The patient's general health must be thoroughly considered when using these injectables.[2] Close co-operation between chiropodist and physician will be of benefit to the patient.

The basic mechanical problem is structural and therefore of a static non-correctable nature. However, the acute problems are secondary to the structural difficulty, and are readily amenable to treatment. While these problems are not primary, they must be alleviated before the long-range therapy is instituted. The most common difficulty that is encountered and appears to be common to all geriatric patients is the loss of plantar fatty padding. This may be due to a general absorption of fat or a localized increase in pressure forcing the fatty padding away from the areas of maximum pressure where it is most needed. This problem is of prime importance and may be corrected by a multiplicity of methods. A reasonable diagnostic ability and a cognizance of the underlying problems will enable the chiropodist to treat the patient adequately.

Balanced appliances[3] are, in my opinion, the best method of alleviating this condition. These appliances serve the purpose of aligning the foot to the walking surface.

Balanced appliances have two planes—one that coincides with the floor of the shoe and one that coincides with the plantar surface of the foot. They encourage weight bearing on all normal weight bearing areas. Balanced appliances contain the entire foot in a form-fitting shell, thus maintaining control of all foot action.[3]

This appliance must be made over a model of the foot. The method and technique of taking the impression will determine the effectiveness of the appliance. A slipper cast is a simple and effective method for this type of appliance. The positioning of the foot during the "casting" will determine the corrections in balancing. With the geriatric it is advisable to balance the foot in its neutral position without any forced correction. Therefore, the cast must be made with the foot in its neutral position. This position is one in which the foot is at a right angle to the leg in all planes. This can be accomplished easily by using a split leg rest extended to the insertion of the tendo-achilles and raised to the height at which the foot will naturally assume a right angle. It is not necessary to force an exact right angle in the dorso-plantar position. However, the right angle must be maintained in the medio-lateral plane. There should not be any exaggeration of any of the bony structures, as this will cause undue pressure.

Molded appliances have the basic effect of distributing pressure over a large area. They are useful where there are small areas of extreme pressure. Additional pads may be added to the mold to compensate for the various specific problems. The incorporation of an extension metatarsal pad, as will be described later in this paper, has a desirable effect in most cases, especially those with forefoot complaints and arthritis of the metatarsal phalangeal articulations. Other commonly incorporated pads which would be used for individual specific problems are the dancer's pad,[4] reverse dancer's pad, double dancer's pad and "U" pad. When using molds, extreme caution must be exercised not to create any areas of pressure. Crests and other elevations should be decreased and kept to a minimum.

The true effect of a molded shoe is the same as that of a cast. They are useful in those acute conditions where immobilization or partial immobilization is desired.

Caution should be exercised in their use for extended periods of time, especially in osteo-arthritics. When using molded shoes, the same precautions must be taken as for molded appliances. In addition, adequate measures must be taken to insure ample room for the toes, otherwise these debilitated patients may develop lesions that will be difficult to heal.

Shoe paddings serve a useful and necessary purpose in treating the geriatric patient. It is inadvisable to strap the pads to the foot where this can be avoided, as the geriatric skin is not sufficiently supple to withstand the rigors of adhesive tape. There are conditions under which you will be unable to place the patient in the proper appliances. In these cases, shoe padding will of necessity be the treatment of choice.

The extension metatarsal pad is probably the most important pad used in the treatment of the geriatric. The highest portion of this pad should come just behind the lesser metatarsal heads in a straight line and angle posteriorly behind the first metatarsal head and its sesamoids. The area of highest elevation should be from one-fourth to three-fourths inches wide and the anterior skive should extend forward almost to the web of the toes. The pad should extend posterior, the lateral edges being at the shafts of the first and fifth metatarsals to the anterior edge of the calcaneus. The pad should be evenly skived to a feather edge on all sides and have no sharp edges. This pad acts to replace the fatty pad by cushioning and keeping the metatarsal heads in a straight line. In those conditions where there is anterior displacement of the fatty pad, the leverage action will tend to pull the fat back under the heads.

The button type of metatarsal pad is of little or no value in the geriatric and tends to create trauma.

The inner longitudinal pad has a limited value. Care should be taken to avoid any unnecessary pressure on the midtarsal articulations. Heel pads and dancer's pads in their various forms are used in the treatment of specific conditions. Their primary use is the accommodation of acute painful conditions. The chiropodist should not hesitate to design his own pad for the specific problem at hand.

Removable toe pads such as toe shields, crests, traction and other pads, are of great value in the treatment of specific types of problems affecting the toes. These pads may be made of felt, latex, acrylic resins or other materials suitable for this purpose. Care must be taken to avoid an excess of material between the toes or under the toe sulcus. Where there is a painful restriction of motion in the forefoot, such as a hallux rigidus or limitus, arthritis or subluxation of the metatarsal phalangeal articulations, a metatarsal bar, either by itself or in conjunction with other treatment, when properly constructed and properly placed, will usually relieve the painful symptoms by reducing the trauma normally sustained in locomotion.

A thorough regime of treatment cannot be complete without adequate control of the patient's footgear. While the shoe in itself is in no way corrective, an improper shoe can nullify the effects of an otherwise adequate program.

Because of the debilitated condition usually present in the geriatric, it is imperative that the shoe be large enough and free of any points of pressure. It may be necessary to gradually increase a patient's shoe size as the aged patient may object strenuously to a too radical change in his accustomed shoe.

In no area of chiropody is it so essential to have a positive approach to therapy. The psychosomatic aspect of treatment is of prime importance in the geriatric. He must be constantly reassured that treatment is progressing satisfactorily. However, the

chiropodist must be able to demonstrate a definite increase in the patient's functional ability or an equally definite relief of symptoms.

This can be achieved if the chiropodist is aware of two major pitfalls. Strict palliation with the result that no permanent relief is achieved, is one pitfall. Too radical therapy with the result that it irritates, inflames and generally aggravates the condition, causing the patient to become dissatisfied and fearful of any treatment other than palliation, is the other.

A conservative approach to therapy designed to gradually increase the patient's ability to function, carried forth with patience will result in excellent progress.

168 Boulevard

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AN EVALUATION OF SURGICAL WOUND FLUSHING*

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WITH the advent of the new nonsensitizing antibiotics, the surgeon is presented with a new field of post-operative, antibacterial therapy.

The author has utilized a tetracycline† for the irrigation of two hundred surgical wounds with the incidence of infection being 1.5% following its use. Meanwhile the two hundred control cases which were given oral antibiotic therapy post-operatively yielded an incidence of 7.5%.

To substantiate the rationale for the local use of the tetracycline in clean surgical wounds, a brief discussion of the biochemical concept of inflammation is in order. As the host cells have been damaged by surgical trauma, they release a series of chemical substances which give rise to an inflammatory response. These chemotactic entities of the inflammatory exudate have been isolated as leucotaxin, leucocyte promoting factor, exudin, necrosin, pyrexin, glycolytic factor, and a growth promoting factor. The leucotaxin produces a vasodilatation of the capillaries, diapedesis of leucocytes, and an outflow of plasma containing fibrin, water, electrolytes, and immune bodies into the area. The fibrin acts as a physical barrier to the spread of any invasive bacteria, the water as a diluent for any parasitic toxins, and the immune bodies as either toxin-neutralizers or as agents which prepare the micro-organisms for phagocytosis by the leucocytes (opsonins). Exudin appears later in the inflammatory mechanism and its chief action is to cause a continuous seepage from the capillaries. The leucocyte promoting factor stimulates the bone marrow to increase production of leucocytes. Pyrexin, a euglobulin, is believed to produce an elevation of body temperature in the infected host. Necrosin, a polypeptide, converts the protoplasmic material of the cells into sugars.

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† Achromycin (Lederle Laboratories Division, American Cyanamid Co.) I.V. 100 mg. vials—diluted by 5 cc. of water for injection giving a dilution of 20 mg. per cc.

There is also a migration of tissue histiocytes and macrophages into the area of inflammation along with a biochemical change in the composition of the fluids at the site of inflammation. Oxygen tension decreases, carbon dioxide and lactic acid increase because of the increase breakdown of glucose, with the result that the pH of the medium is lowered, yielding a media which is unfavorable for the growth of the micro-organism.

Along with the above information we must also take into consideration the fact that in a surgical wound there is an area "through which" the blood circulation has been severed. Therefore, in the author's opinion the flushing of the clean surgical wound is much more effective than the immediate post-operative use of oral or even parenterally administered antibiotics. In the former case there is the local bacteriostatic effect of from twenty to one hundred milligrams of a tetracycline available before, during, and after wound closure.

On the other hand, during oral ingestion (which is perhaps the most common method of administering to ambulatory patients) we have a loss of about thirty-three per cent in the G.I. tract, about seventeen per cent in the blood stream as a result of its inactivation by the blood's constituents (particularly proteins), leaving approximately fifty per cent active in the blood stream. This concentration becomes further diluted throughout the three and one-half liters of blood and ten and one-half liters of tissue fluids. This gives a dilution of approximately nine thousandths of a milligram per cubic centimeter of fluid (all statistics being relative to each individual's weight). In most instances this is more than the desired concentration because the range for efficaciousness lies between one millionth to five thousandths of a milligram.

However, we are dealing with a wound "through which" no blood is flowing. The circulation "around the wound" can carry the antibiotic about the area and this will be slight where there is ischemia produced by pressurization (sterile pressure dressing). Therefore, we have an aid in maintaining the localization of any post-operative infection but no prophylactic measure for the prevention of an infection.

The main processes of inhibiting bacterial metabolism by the tetracycline analogues appear to be concerned with oxidation-reduction reactions, fermentation, protein metabolism, and important ion necessary (magnesium) for enzymatic processes. The antibiotic is active against a wide variety of bacteriagenera in a concentration ranging from 0.312 to 1.56 micrograms per ml. It has been used effectively in the treatment of Gram-positive and Gram-negative bacteria, rickettsiae, protozoa, and certain virus-like organisms. It has only limited activity against B. proteus and Pseudomonas aeruginosa.

It would seem that in wound irrigation we have a prophylactic therapy which enhances the body's mechanisms of defense to a greater degree than other means used. If the surgeon utilizes local wound prophylaxis along with aseptic technique and meticulous post-operative care, he can expect a marked reduction in post-operative infectious complications.

1327 N. Clark St.

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THE DRY, SCALY, FISSURED AND ECZEMATOID SKIN

A Supplementary Report on a New Concept and Treatment

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About a year ago this investigator proposed a new concept in the treatment of a common dermatologic condition which every medical practitioner is faced with almost daily—namely, the dry, scaly, fissured and eczematoid skin.

Many factors have contributed to an increasing incidence of this condition to the point where it has become a major problem. New phases of practice such as geriatrics, dermatologic manifestations after the use of antibiotics or other allergic sequellae, new and modern detergents, etc., have focused our attention and efforts toward alleviating this irksome pathology. The ever present watchfulness necessary in the treatment of diabetic's integument or the skin sequellae after a siege of fungus infection have been with us for a long time.

In the past, our armamentarium was replete with endless products designed to "replace the oil" in the skin. The newer concept propounds the theory that dry rough skin common with these complaints is the result of a lack, not of lipid or fat material, but of water. This is, of course, in contradiction to previously widely held view that roughened dry skin needed a lubricant, and preparations that were oily or greasy in nature were usually prescribed. Repeated failures demonstrated that these agents were not the answer. In a previous publication[1] we showed the reason. It bears repetition at this point.

To understand the rationale proposed in this study, the clinical picture, the histology and the pathology of eczematoid skin must be reviewed. Basically, in any of these conditions the clinical picture presented might be a dryness, roughness, lack of flexibility, scaling, fissuring or a combination of any of these. In the more advanced stages there are apt to be some eruptions present or a secondary pyogenic infection. Often there is a superimposed contact dermatitis resulting from self-medication or over-medication.

The stratum corneum, the outermost layer of the skin, is a laminate of flattened cells. In the normal skin these cells lie smoothly on one another. However, when these cells become deranged they lose their laminate structure—they stick up, so to speak, and roughness is the result.

We mentioned that the derangement of the stratum corneum was a result of lack of moisture in the cells, rather than a lack of fat. This can be proven by a very simple experiment, as shown by Blank[2, 3] and others.[4] A slice of cornified stratum corneum is obtained from a plantar callus. This is permitted to dry out until it becomes very hard and brittle (in spite of any natural oils that it may contain). Any attempt to soften this hard, brittle skin with petrolatum, lanolin or olive oil etc., meets with complete failure even though contact with these oils or fats is maintained for many months. If, however, this material is allowed to absorb a little moisture—such as immersing it in a glass of water for a short time, it becomes soft and pliable.

Normal healthy skin is capable of maintaining an adequate level of moisture in the stratum corneum because it receives moisture from the underlying tissue and under certain thermal conditions from the sweat glands. It also loses some moisture to the atmosphere, but under normal conditions an optimal equilibrium between moisture received and moisture lost is

maintained and the skin remains soft and flexible.

This balance may be disturbed by extrinsic or intrinsic factors. Whichever it may be, the pattern of lamination of the cells of the stratum corneum is distorted. The cells are no longer contiguous but form an interrupted pattern, so that even if the extrinsic factor has not injured the lower cells and they continue to feed moisture to the uppermost layer, the fissuring and roughness of these cells permits the moisture to be dissipated into the atmosphere with further dehydration the result. If for some reason the underlying cells (intrinsic factor) do not provide sufficient moisture to the stratum corneum (as in the diabetic and the geriatric patient) the result is again the disturbance of the lamination of the cells with the loss of whatever moisture is present. Thus a vicious cycle is instituted.

Notwithstanding the importance of water in the dry skin syndrome, it must be appreciated that skin is essentially fat and fatlike material and water. Skin has been called by some investigators analogous, a water in oil emulsion. Such an emulsion is characterized by having the oil as the continuous phase and the water as the interrupted phase. It, therefore, is logical to assume that the restoration of the dynamics of moisture equilibrium in the stratum corneum should be best accomplished by the use of a water in oil emulsion. A specially processed emulsion of 50% water in a base of waxes, petrolatum and an emulsifier, sorbitan sesquioleate, was used in this study.

In an earlier paragraph we mentioned the use of oily and greasy substances which have in the past been used to lubricate the dry skin under the premise that lost fat must be replaced. The use of such products at first seemed to be of some help but not because they replaced fat. The greasy substance did, however, seal off the stratum corneum preventing further moisture loss to the atmosphere, and permitting the stratum corneum to retain the moisture furnished (when functioning) by the deeper tissues. This form of treatment proved generally unsatisfactory since an abnormal condition was artificially created. Organisms which might give rise to infection were effectively trapped beneath the greasy film. Often the very moisture it was seeking to entrap gave rise to skin maceration. The greasy occlusive covering is of little help when underlying tissues are not supplying sufficient moisture as for example in the diabetic and geriatric patient. Still another consideration is the danger of creating a worsened situation because of allergic reactions and contact dermatitis as the result of the various chemicals that are kept in such close contact with the epidermis by the greasy occlusive ointment.

The study of this problem was undertaken by James Gant, Chief of the Dermatology Clinic of the V.A. in Washington, D. C.[5] In seeking more efficient methods of treatment, he considered the possibility of utilizing an ointment which would not interfere with the normal dynamics of sick skin trying to heal itself, but which would support this natural process. He was well aware of the need for avoiding any substance which in itself might further traumatize, sensitize or superimpose a contact dermatitis on already irritated skin. He, therefore, used Polysorb Hydrate,®[1] which he believed would effectively seal off further moisture loss from the stratum corneum and promote a dynamic exchange between the water phase of the hydrated ointment and the dehydrated tissue. Because of the basic hydrophilic character of a water-in-oil emulsion, moisture exchange readily takes place between the skin and the hydrated ointment avoiding the macerating effect of a completely occlusive barrier substance.

®[1] E. Fougera & Co.

TABLE I
Results of Polysorb Hydrate (Water-in-Oil Emulsion) Therapy on Ambulatory Patients

Condition	No. of Patients	Therapy	Results
Post Fungal	4	2 weeks of therapy with water-in-oil emulsion	Return to complete normalcy.
Diabetic & peri-vascular	18	Daily application 4 wks.	Skin pliable. No scaling. No pruritis.
Senile skin (no pruritis)	20	Application b.i.d.	Smooth, pliable skin. Color good.
Contact Dermatitis	3	2 weeks b.i.d. after contact was eliminated	Return to complete normalcy.
Over medication (self-medication)	1	2 days of antiseptic wet dressing followed by 12 days of water-in-oil emulsion	Complete restoration of normal skin.

TABLE II
Comparison of Results of Two Groups After Three Weeks of Controlled Therapy

Conditions	Group A (hand lotions, lanolin, etc.)	Number of Patients	Group B (Polysorb Hydrate)	Number of Patients
Senile, parchment-like skin	Temporary 1-2 hr. improvement only	12	Soft smooth skin—no flaking or cracking of integument	11
Perivascular, Hemiplegics, Orthopedic	No significant improvement	14	Marked improvement—skin soft and pliable no new ulceration	15
Post-Operative, mental, etc.	Mild improvement for short periods	8	Complete elimination of all dry skin symptoms	8

A series of 114 patients were treated by the author with Polysorb Hydrate for various dry skin problems. The patients were instructed to apply small quantities of the bland emulsion to the affected area and rub it in well. This was repeated 2 to 4 times a day with the intention of maintaining a thin invisible film of the emulsion on the skin for as much of the time as possible. They were particularly instructed to apply the medication before retiring. Of the 114 patients, 46 were ambulatory (Table I), and the remainder were in a private nursing home.

In addition, a study of the geriatric and other skin problems was undertaken at the College Nursing Home in Flushing, New York. In such a situation, control of both patient and therapy was obtained through the excellent cooperation of the nursing staff. The patients of this group consisted

of post-operative convalescents, elderly senile patients, post-hemiplegics, diabetics, mental patients, perivascular patients, and orthopedic invalids. Their ages ranged from the early 30's to middle 90's. Most were under medical treatment and all received 24-hour nursing care (Table II).

The 68 patients in this part of the study were divided into two groups of 34 each. Each group had skin problems that were as nearly similar as possible. Group A was allowed to use their usual skin emollients—body oils, lanolin, vitamin A preparations, cosmetic hand creams, etc. Group B was put on water-in-oil emulsion therapy exclusively.

At the end of the three-week period, there was a marked difference in the results obtained in the two groups. Group A, using lanolin, oils, hand creams, etc., had but short temporary periods of relief. Their dry skin persisted in the same condition, and in a few instances became worse. Group B patients, using Polysorb Hydrate, had an almost complete elimination of their dry skin problems. Where there was a dry, hard cracking integument, the skin was now soft, pliable and had excellent color. Complaints from this group were eliminated, and most patients were very emphatic over the relief they obtained.

As a further control, Group A was put on Polysorb Hydrate therapy at the end of the initial test period, and a steady improvement of their dry skin problems followed. At the end of this group's second three-week period, there was a marked improvement over the first three weeks, as shown by the relief of dry skin conditions. Scaling and fissuring disappeared and the skin was soft and pliable. Pruritis was no longer a problem and patients remarked on their comfortable condition.

The following cases serve to illustrate some of the dramatic results achieved:

Case 1: *J. C.*—male, 18 years old. Active fungus infection. Severely irritated by self medication. Secondarily infected with staph. aureous. $KMNO_4$ foot soaks for 5 days, undecylenic acid compound for 1 week. Polysorb Hydrate for 2 weeks. Results are shown on before and after photographs.

Case 2: *M. R.*—female, 44 years old. Cerebral Palsy since age 6. Mental involvement with phobia of cleanliness. Washes her hands and feet with soap and water at least 30 times daily. Reasoning with patient was useless. Hands and feet were shriveled, dry and as rough as coarse sandpaper. Nurses applied Polysorb Hydrate to hands and feet 5 times daily. In spite of continued washing with soap and water, hands and feet became smooth, unwrinkled and skin became pliable after 3 weeks of therapy.

Case 3: *H. S.*—female, 69 years old. Diabetic, arteriosclerotic. Skin on feet and legs very thin and flaky. Dry and itchy. Scratching caused excoriation and bleeding. Polysorb Hydrate b.i.d. for 3 weeks returned skin to a soft, pliable, non pruritic condition. Danger of secondary infection diminished.

The uniform success of this series was extremely gratifying, but we must emphasize that all cases were chosen for the simple dry, pruritic, and eczematoid skin. Where there was a superimposed bacterial infection due to scratching, a topical antibiotic ointment was first used to combat the infection. This treatment was then followed with the application of the water-in-oil emulsion.

In summary, the results obtained in treating the dry skin problems of 114 patients dramatically proved the value of the use of Polysorb Hydrate. This therapy may be used safely and effectively to treat the many cases of dry skin seen by the practicing podiatrist, general practitioner or dermatologist.

Keith Theatre Building

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MORTON'S METATARSALGIA: UNILATERAL MULTIPLE NEUROFIBROMATA*

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SINCE the recognition of the absolute etiology of Morton's Metatarsalgia,[23] i.e., intermetatarsal neurofibroma,[4, 19] many articles have been written relative to the best surgical approach to the tumor.[20, 21, 24, 25, 30] Notwithstanding the arguments in favor of the plantar approach,[24, 25] our profession has long held that plantar incisions are the forebears of trouble which can best be avoided if another approach is feasible. The dorsal approach of McElvenny,[5,19] is without doubt the most acceptable approach among foot surgeons.

There has been considerable difference of opinion as to the cause of the pain and the location of the cause. Morton[18, 22, 23] was the first to suggest that a pinching of a plantar nerve was the source, though his observations indicated it was an impingement between the fourth and fifth metatarsal heads. Other opinions have clouded this first etiological concept to some degree[16] though Betts[4] and McElvenny[19] have cleared the air.

Therapy Developed

Various forms of therapy have been used prior to the advent of neurectomy, and have a great deal of usefulness to this day. Proper fitting shoes,[1, 14] plantar padding or appliances with an elevation behind the metatarsal head involved,[29, 33] therapeutic nerve blocks using anesthetics without vasoconstrictors,[12, 13] injecting the nerve with absolute alcohol,[17] toe splinting,[7] orthopedic heels, and comma bars[3, 15] and the various forms of physical therapy: all have an element of useful application. Many can be used where surgical intervention is inadvisable.

Suggested surgical measures range from the curettement of intervening bursae,[6] amputation of the involved metatarsal heads,[10, 26] transplantation of the long extensor tendon into the affected metatarsal head to elevate it,[21] and finally to excision of the neurofibroma.[4, 19, 27, 28, 31]

Discovery of a Clinical Entity

Though it is the writer's purpose to draw attention to a clinical entity uncommon enough to appear not to have been reported thus far, a number of observations will be included with the hope of stimulating others to express their observations. It might be added that the technic of plantar neurectomy as it applies to this pathology will not be discussed. Others have covered this satisfactorily. In my series all approaches were dorsal and up to the web. The results have been excellent. I do, however, wish to emphasize the importance of recognizing this clinical entity both for the discomfiture it will save the patient as well as embarrassment to the doctor.

Some years ago I had the opportunity of examining the post-operative results of another doctor's bilateral neurectomy in which case the female patient complained of the same agonizing pain in each foot she had had prior to surgery but which centered in an adjoining intermetatarsal interspace. A crepitating mass was palpable between the adjacent metatarsal heads, and elicited intense pain when impinged against one of them. A nerve block gave temporary relief to each foot. Diagnosis was "neurofibroma-bilateral." The patient had seen the pathologist's report relative to the tissue previously removed and was satisfied that the diagnoses were identical. She wanted to know if I had ever heard

* Awarded Honorable Mention in the William J. Stickel Annual Awards for Research in Chiropody-Podiatry for 1958. Presented at the Annual Meeting of the American Podiatry Association in Washington, D. C., August 1958.

of anyone having two "nerve tumors" in one foot and I had to admit that the literature on the subject was small with no such report in it up to that time. Her next query was one asking how the surgeon who had removed her other neurofibromata, and who had an international reputation, could miss these. I never did have the opportunity to definitely establish or verify my diagnosis for she went back to her home town to think it over.

Later on a male about age 46 came to the office complaining of a lancinating pain in the area of his right third toe. A mass was palpable between the metatarsal heads in both the second and the third metatarsal interspace. A nerve block was done in the third interspace with partial relief. Complete relief was obtained by injecting in both interspaces, though when the anesthesia left the pain recurred. In July 1949 incisions were made in both the second and third metatarsal interspaces and large neurofibromata were found in the plantar metatarsal nerves at their bifurcation to the toes. Resection gave complete relief and with no recurrence. This patient was examined just a few months ago. There was no sign of recurrence.

Subsequently six other patients have been operated upon (see Table III) with excellent results. On five of the seven cases, pathologists' reports were obtained; three reports were "plexiform neurofibroma" and two were just "neurofibroma." On the other two cases no tissue was sent to the laboratory as the tumors were quite large and their identity obvious.

Diagnostic Nerve Block

Two of the seven patients had to undergo surgery for the removal of the second tumor because the entity was not recognized at the first examination. It was only after the patients returned to complain of the same discomfort a month or more later that the other neurofibroma was discovered. It is now the writer's practice to use a diagnostic nerve block in each instance to ascertain: 1) the degree of relief

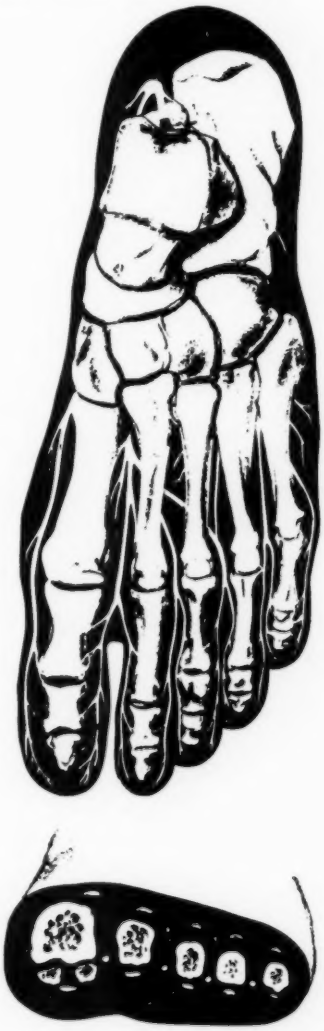

FIG. 1

Upper—Irrespective of the various theories expounded as to why a neurofibroma should occur in the third metatarsal interspace, the tumor can occur in any one of the interspaces, and occasionally does so in two on the same foot.
Lower—This cross section through the metatarsal heads indicates the approximate relationship of the plantar metatarsal nerves to their adjacent metatarsal heads.

TABLE I

UNILATERAL SINGLE NEUROFIBROMA

	Male						Female						
	Right			Left			Right			Left			
Interspace	1-2	2-3	3-4	1-2	2-3	3-4	1-2	2-3	3-4	1-2	2-3	3-4	
20-30		1	1					1	3			3	
31-40									3		2	1	
41-50			2				1	1	1		3	7	
51-60	1							2	3		3	1	
61-70												3	
Total	1	1	3				1	4	10		8	15	43

It will be noted without surprise that the majority are females. Though the five male cases had their tumors in the right foot, the females were troubled predominantly with the left foot.

TABLE II

BILATERAL SINGLE NEUROFIBROMATA

	Male						Female						
	Right			Left			Right			Left			
Interspace	1-2	2-3	3-4	1-2	2-3	3-4	1-2	2-3	3-4	1-2	2-3	3-4	
20-30									2			2	
31-40													
41-50									4			4	
51-60			2			2			2			2	
61-70													
Total			2			2			8			8	20

The tumors developed bilaterally in identical metatarsal interspaces. This would seem to indicate that a careful examination should be made of the same interspace in the opposite foot in all cases complaining of unilateral pain.

obtained, 2) the duration of the relief, 3) the degree of resolution.

Symptoms were variable in each case though all of them had tenderness in the interspaces involved, and most of them had palpable, crepitating masses between the metatarsal heads. Some of them had an accommodation soreness under the first metatarsal heads of the affected foot, primarily from favoring the outer side of the foot.

With no claim at accuracy it is estimated that one-fourth of all cases diagnosed as Morton's Neuralgia will respond to palliation. One of the finest therapies is the injection of one cubic centimeter of 1% plain Novocain or 1% plain Xylocaine in the metatarsal interspace, about one inch proximal to the metatarsal heads, depositing it toward the inferior surface of the shafts and equidistant from each. A ¼ inch metatarsal raise is then placed behind the

metatarsal head that is external and adjacent to the injected and involved nerve. The patient is ordered to return in five to seven days at which time she will report to you as to the measure of relief she received. If she has definite improvement following the disappearance of the anesthesia it is well to give her a few additional treatments to observe if the improvement is progressive. It is our belief that the relaxing effect of the plain anesthetic solutions on the vasoconstrictors, and the relief of pressure by elevating one of the metatarsal heads thereby widening the metatarsal interspace, permits the swelling of the neurolemma to regress and the pain to abate. This appears to happen in about half of the cases I have treated though a good half of these come in for subsequent treatment or neurectomy. Thus the expressed view that about 25 per cent of all cases resolve with treatment.

Should the neurofibroma be palapable after such therapy it may be kept comfortable by the use of an appliance with a metatarsal elevation. Some patients seem to have continued comfort this way whereas others have to return for surgical intervention. Injections of hydrocortisone has been of no value.

If the relief during the anesthesia period is complete the condition involves a single nerve provided you have used a small amount (one c/c) of anesthesia. A large amount could flood over into the adjoining metatarsal interspaces. If the relief is only partial that first day, reexamine the foot to determine the source of remaining discomfort. Once located, that nerve should be blocked along with the previous one, using one c/c for each. If relief is complete during the anesthesia period you may have another neurofibroma.

It should be noted that a neurofibroma can occur in any of the metatarsal interspaces,[11, 24, 25, 34] which my experience (see Tables One and Two) tends to verify.

TABLE III

UNILATERAL MULTIPLE NEUROFIBROMATA

Patient	F	M	Age	Location of Tumors
C. E.	X		28	Lt. 2-3; 3-4
E. H.	X		35	Rt. 3-4; Lt. 2-3; 3-4
H. H.	X		46	Rt. 2-3; 3-4
C. F.	X		49	Rt. 2-3; 3-4
V. M.	X		51	Rt. 2-3; 3-4
E. A.	X		63	Rt. 2-3; 3-4
G. W.		X	50	Rt. 2-3; 3-4

There was some question whether Patient E. H. should be listed in Chart Two. She was not. Note the range of age groups, that the right foot is most commonly affected, and that the majority are females.

Though others have excised them from the fourth metatarsal interspace I have not had occasion to.

Surgical Observations

In one case in which the tumor had been freely palpable prior to the surgery, the neurofibroma was not evident when the usual exposure was made. The plantar nerve was picked up anterior to its bifurcation and followed back. A convolution containing the tumor was found under one of the metatarsal heads. In effect the metatarsal head was actually resting upon the tumor.

In another case in which the pre-operative diagnosis has been "intermetatarsal synovial cyst," and in which there were no neurological symptoms or history, the synovial cyst was found to encapsulate a large neurofibroma. The cyst, which had been large enough to separate the metatarsals as evidenced on the roentgen views, had relieved mechanically all pressure on what would have been a very painful neurofibroma.

Each growth in the series occurred at the bifurcation of the plantar metatarsal nerve and did no extend along the digital

branches. Though some were bulbous the majority extended proximally along the plantar metatarsal nerve.

Though roentgen examination was made in every case, separation or spreading of the metatarsals was exceptional rather than commonplace.

Post-operatively the results were most gratifying.

Summary

1. A new clinical entity has been discovered and described.
2. Some points in diagnosis are discussed.
3. The findings on a series of 78 plantar neurectomies on 60 patients are given. Seven patients were afflicted with unilateral multiple neurofibromata.
4. A few observations are made relative to diagnosis and to some findings in the operating room.
5. A differential or diagnostic nerve block is discussed.
6. A nerve block should be done on every case of Morton's Neuralgia to eliminate the possibility of multiple neurofibromata unilaterally.
7. Unilateral multple neurofibromata were observed in seven out of 60 cases. An examination of the literature has failed to reveal any report of this clinical entity.
8. When a positive diagnosis of neurofibroma has been definitely established, the same interspace of the other foot should be carefully examined.

Kresge Bldg.

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PHYSICAL MEDICINE IN FOOT ORTHOPEDICS*

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One of the most important adjuncts in the orthopedic field in chiropody is the physiotherapy available to enhance muscle rehabilitation, alleviate pain, release stress and strain, eliminate contractions, and to generally assist in the normal function of the human foot.

In the time allotted to me under the foot orthopedic section, my only desire is to review with you the types of physio-therapy, where applicable, and some techniques. Many of these techniques, you may agree or disagree, may be used as I have successfully over a period of 19 years and thousands of treatments.

We find our patients coming into our offices with pain, edema, contractions, inflammations, some local and some general, the usual symptoms of tiredness, aching, strain, cramping of muscles, posture problems, etc. Our most important factor is history and diagnosis. Once the diagnosis has been established, it is important that we set up a treatment schedule that will best help the patient with his problem.

Are we interested in the edema, the inflammation, the pain or the underlying factors? Is the problem acute or chronic? Can we alleviate or eliminate? You notice "cure" is not part of the vocabulary. If it is within nature's power to help the individual, with an assist from us, that is our greatest joy.

The various modalities available to us, and I am sure you are all familiar with them, are: 1. Hydro-therapy; 2. Galvanism; 3. Sinusoidal (contractile) currents; 4. Infra Red; 5. Ultra Violet; 6. Intermittent Venous Occlusion; 7. Ultra Sound or Ultra Sonic; 8. Short Wave; 9. Microtherm; 10. Cold and Hot Packs; 11. Many others with which I have had little or no experience.

The term most commonly applied to these modalities in the treatment of human ills is Physical Medicine. As with general medicine, the diagnosis is important, and the treatment is aimed at the problem just as in general medicine. We can try to be specific.

In acute cases of sprain, contusion, severe strain, wherein the patient is seen within hours of the original trauma the treatment of choice is cold packs or cold hydrotherapy. The hydro-therapy should be 65 to 75 degrees.

In chronic problems the moderate temperatures are important such as hydrotherapy at 90 to 100 degrees, short wave at a low reading or galvanism for longer periods of time at low milliamperage.

For subacute problems, the hotter modalities are essential such as hydro-therapy at 102 to 104 degrees, galvanism for greater lengths of time, short wave or micro-therm treatments at short intervals between treatments, infrared or hot packs.

Care must always be exercised in determining the patient's general condition, especially in treating with heat or cold. Determine that the patient is not diabetic, luetic, or has a peripheral vascular ailment that tends to nullify the perception of heat and cold. A spinal lesion or trauma to the back or head of fairly recent nature could dull the senses so that hot and cold are not sensed properly.

Some specific lesions and their treatment are as follows:

Acute Sprain

(Within a few hours after trauma)
(Always X-ray)

a. Cold packs

* As presented at the Annual Meeting of the American Podiatry Association, Washington, D. C., August 1958.

b. Cold hydro-therapy 65 to 75 degrees for 15-twenty minutes and strap—or galvanism plus magnesium sulphate (positive pole) 150 milliampere minutes and flexible casting
c. 3 days later hydro-therapy at 102 degrees plus strapping.
d. Continue this treatment every 5 or 6 days until completely improved.

Ankle Sprain Several Days After Initial Injury

a. Hydro-therapy at 104 to 105 degrees for 15 minutes or histamine ionization for 100 M.A.M. plus flexible casting. Continue every 5 days.

Chronic Ankle

a. Hydro-therapy at 104 degrees for 15 minutes twice a week, for 4 to 6 weeks with high Dye strapping, gradually lowering tibial strapping, then low Dye and finally nothing except proper shoes with some modification for proper foot balance.

In So-Called Weak Foot or Muscular Imbalance

a. Sine wave started at a low, slow contraction with electrodes to the plantar area of both feet or to posterior muscles of the leg. Treatment is 2 minutes. At each subsequent visit 2 minutes are added to this modality until 10 minutes is reached at a moderately contractile current.

This treatment exercises and relaxes muscle, breaks up adhesions of disuse and stimulates circulation to the body of the muscle. The Anterior and Posterior Tibialis, and the Flexor and Extensor Digitorum Longus also are stimulated. A Peroneal spasm would have to be given separate treatment.

b. Hydro-therapy at 102 degrees is then given to relax the muscles and ligaments and further stimulate the circulation.
c. Manipulation and strapping are then used in conjunction until such other care or treatment is necessary or desired by the doctor.

In the Treatment of Morton's Toe or Metatarsalgia

a. Hydro-therapy for relaxation of interosseous ligaments and stimulation of circulation for 15 minutes at 102 degrees.
b. Ultrasonic treatment to specific area of pain 1.5 watts for 5 minutes. At complaint of pain the wattage is lowered. Use with or without hydrotherapy.
c. Other treatment may be used. Mechanical certainly, and possibly hydrocortisone or B-12 injection, or surgery for a neurofibroma, where indicated.

Chronic Edema of Ankle

a. Certainly pre-determine that there is no physical debility.
b. If edema is of an inflammatory nature the modality of choice is magnesium ionization 150 M.A. every 5 days.
c. If mechanical in nature, we treat with sine wave, hydro-therapy at 102 degrees and follow through with strappings and mechanical orthopedic aids.
d. In chronic ankle edema we attempt to treat with hydro-therapy at 104 degrees and compression bandages such as Elastoplast or Dalzoflex, etc.

Peroneal Spasm

a. Again pre-determine the cause.
b. Treatment is given with the 2 electrodes of the sinusoidal current applied to the origin and insertion of the Peroneus Longus. The effect desired is to tire this muscle into relaxation and a moderately strong contractile current is used for 10 minutes followed by hydrotherapy for 15 minutes at 104 degrees or ultra-sound

along the length of the muscle for 5 minutes at 2 watt output. Strapping is used (high Dye is my preference). Injection therapy can of course also be used, but we are here discussing physiotherapy.

Heel Spurs: Bursitis: Local Inflammatory Problems

1. Determine the cause. Complete blood count very often important.
2. Use mechanical treatment where indicated (appliances or shoe padding).
3. Ultrasonic treatment for heel spur 5 minutes at 1.5 to 2 watt output daily or 3 times a week for 2 or 3 weeks plus strapping during acute phase.
4. Hydrocortisone or ½% cortisone ionization 100 M.A. (positive pole) to bursal area or inflamed area, twice a week until inflammation and pain subsides. Histamine ionization is also effective on positive pole and KI ionization on the negative pole seems to give excellent results. Again 100 M.A. twice a week.

Many other problems of the feet can be helped with physiotherapy, namely verrucae with galvanism; post fracture care; circulatory problems; the arthritides; gout; to name a few. Keeping an individual's muscles active in post cerebral accident and spinal injury problems in conjunction with general care by his physician is most important.

In the time allotted, I hope I have whetted your appetites.

25 E. Washington

BASIC OFFICE SURGERY ROUTINE

ALAN K. WHITNEY, D.S.C.
Natick, Mass.

THOSE practitioners who are contemplating or now entering the arena of foot surgery would perhaps be aided by a general outline of steps constituting the basic office surgical procedure.

Having observed, or participated in, several hundred foot operations, it is felt that a fundamental podiatric procedure exists even though subject to minor variations by the individual surgeon. It is our intent herein to present a useful guide which can be referred to with some degree of assurance.

Procedural Outline

I. Preoperative Procedure
  A. Clinical examination
    1. The Condition
    2. The Circulation
    3. The General Health
  B. X-rays, Photos and Models
  C. Laboratory Tests
  D. Preoperative Instructions and Medication
II. Preparations for Surgery
  A. Sterilization
    1. Operative Pack and Dressings
    2. Gowns and Gloves
    3. Instruments
  B. Operating Room
III. Operation
  A. Consent to Operate
  B. The Foot Prep
  C. Layout Procedure
  D. Hand Scrub, Gowning, Gloving
  E. Anesthesia and Hemostasis
  F. Operative Technique
  G. Postoperative Instructions and Medication

IV. Postoperative Procedure
   A. Re-dressings and Suture Removal
   B. Surgical Records

A few remarks are offered for clarification of each topic as outlined in the preceding. Being basically an outline, no delusions as to the completeness of this discussion are entertained.

Evaluating the Condition requires a knowledge as to the relevant history and present nature of existing pathology in order that the proper surgical technique may be chosen.

Evaluating the Circulation means detecting the presence of arterial, venous and lymphatic problems which would invite infection and retard healing.

Evaluating the General Health involves a search for those systemic illnesses which affect local or general recovery. Such conditions notably include diabetes, anemia, hyperthyroidism, hemophilia, malnutrition, and cardiorenal disease. The blood pressure, oral temperature, pulse rate and respiration are routinely checked and recorded.

Roentgenologic Study of the area is essential both as an aid to diagnosis and as a record of the pre-existing disorder. Soft tissue work is often better recorded by photographs taken before and after operation. Plaster models can serve to demonstrate orthodigital progress and it is reasonable to assume they could be employed well by the surgeon.

Laboratory Tests may be considered as basic and specific. Basic tests usually include the complete blood count and urinalysis. When urine sugar is detected, the fasting blood sugar level is obtained. Other more specific tests may be ordered where certain conditions are suspected.

Preoperative Instructions may be mimeographed or printed in a form similar to the one shown here:

Preoperative Instructions

For _____

Arrange to have someone accompany you to and from the office.

Bring or wear your roomiest laced shoe to allow space for the dressing.

Take medication as directed.

_____

Doctor's Signature

Concerning preoperative medication, one of the barbiturates, such as Phenobarbital[R1] or Seconal,[R2] may be provided. Such medication may be given the patient to be taken previous to arrival at the office on the day of surgery.

Sterilization of operating packs, gowns, gloves, and instruments is best accomplished by autoclaving. Sharp instruments and heat sensitive materials are immersed in a germicidal solution for several hours. Dressings, which include sponges, roller gauze and surgitube, may be sterilized either in the operative pack or separately in individual containers.

The Operating Room must be simply appointed and easily cleaned. Good lighting, heat, and ventilation are important. The operating table should be comfortable and adjustable to a suitable height. An oxygen tank should be available to meet with emergency situations which may arise.

A **Consent Slip** should be routinely employed and, in the case of a minor, parents must give their written approval. These forms may be brief. A convenient one is:

Operative Consent Slip

Date_____

I (We) hereby give full consent to (Doctor's name) to render surgical treatment to (patient's name) on this date.

Signed_____

_____

The Foot Prep of today is generally of an aqueous character. After donning a clean cap and mask, the skin oils are removed with a solvent such as benzine. The entire

[R1] Burroughs Wellcome & Co. [R2] Lilly

foot is next scrubbed with hexachlorophene soap, rinsed with distilled water, then painted with a tinted aqueous, antiseptic solution. Following a thorough "skin prep" the foot is covered with a sterile towel to discourage recontamination.

The Laying Out Procedure involves a careful arranging of materials, instruments, and dressings so as to allow easy access and efficient operation. At this time one must guard diligently against thoughtless contamination of an otherwise sterile field. Before the hand scrub is started, it is imperative that all details and preparations have been observed.

The Hand Scrub which includes hands and forearms to the elbow is conscientiously executed with brush and hexachlorophene soap followed by an aqueous, antiseptic rinse. The hands and forearms are then dried with a sterile towel. The sterile gown is then picked up by the neckband and donned without contacting its outer side. It may then be tied by the assistant. Sterile talc is rubbed on the hands after which the gloves are self-applied. A nonsterile assistant should never handle the gloves.

The Anesthesia, in minimal quantity, may now be introduced and it must be reiterated that vasoconstricting elements should be avoided, where possible, with local anesthesia of the digits. Hemostasis may be obtained, however, through the use of the toe, foot, leg, or thigh tourniquet, the time of application being noted and appreciated.

The Operation proceeds in accordance with the nature of the condition and the selected technique.

Postoperative Instructions vary little and are most conveniently printed or mimeographed somewhat as follows:

Postoperative Instructions

For _____

Rest and elevate foot for 48 hours. When on feet wear shoes, not slippers, for better support.

Keep bandage clean, dry, and in place.

For pain, take medication as directed. If pain persists, place a dry cold pack, or ice bag, over the area for 15 minutes. Repeat, if necessary.

Some bleeding into the dressing is usual. If unduly prolonged or excessive, notify us.

With any other questions, please phone our office.

Your next appointment for redressing is on _____ at _____

(Doctor's Signature)

A prescription for a postoperative analgesic is given the patient before leaving the office. The newer non-narcotic agents are finding favor among podiatric surgeons.

Postoperative Antibiotics are administered according to individual requirements. Some are now using a diluted intravenous solution of Achromycin®[3] or Signemycin®[4] to flush the wound.

Redressings are usually performed on the second, seventh, and fourteenth postoperative days, unless such a schedule must be altered to meet unusual or unforseen situations. With earlier redressings, only the outermost layers of the bandage are changed in order not to disturb the wound. At later redressing visits the entire bandage is carefully removed, the area inspected, painted with an antiseptic and then covered with a dry sterile dressing. Sutures are usually removable after the seventh postoperative day but, again, this varies in accordance with healing progress.

Surgical Records are absolutely essential for later reference, statistical compilation, and for eventual affiliation with the American College of Foot Surgeons. It is not enough that we know what we have done. Others must know what we have done and we must know it years later.

48 East Central Street

®[3] Lederle ®[4] Pfizer

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

STABILIZING A FLAIL ANKLE WITH THE USE OF CONTOUR SHOES

ALVIN C. LARSON, D.S.C.
Hibbing, Minn.

THIS case involved a female, 82 years of age, who had no lateral ankle stability of the right foot due to an untreated fracture some 25 years ago. Limited walking was with the use of crutches and the wearing of an old-fashioned high top boot on the right foot and no shoe at all on the left. As a result, this left foot had broadened across the metatarsals until it became twice as wide as the opposite foot. This foot measured about a size eight E and the left an eight B. Whatever weight was borne on the right foot would be when the ankle rolled over to the extent that the lateral ankle (fibula) would contact the floor.

As she was not of the type to consider herself a "cripple," the patient would not tolerate an upright leg iron with a strap around the ankle, but she might consider a special contour shoe.* Due to the vast difference in foot sizes, the difficulty in obtaining and fitting high-top shoes, and because no help would be thus attained, the use of a specially constructed contour shoe was decided upon.

Impressions were taken and the lateral heel counter was very rigidly re-enforced with celastic to try and prevent this ankle from rolling over upon weight bearing.

The results have been more than satisfactory from an orthopedic viewpoint. However, the equally (if not more) important factor is the wonderful change which has taken place in this family. Previously, the son carried grandma up steps, in and out of the house, car, church, etc., until a heart condition forced him to give up this strenuous chore. Then she just sat, and at least one member of the family had to sit with her to attend her needs. As a consequence, a happy home life was rapidly declining. Now that she has been brought back to become a member of the household, you can imagine what a great difference this has made in all aspects of this home because now grandma "can do for herself." Sometimes we can do wonderful things, besides relieving a painful foot condition, for many people.

Another interesting case where the contour shoe was of great help can be related in a mine accident case resulting in amputation of the lesser toes and lateral portions of the left foot. This 45-year-old man was hospitalized for nearly one and one-half years, his health was gradually deteriorating due to inactivity and the leg had shortened four inches. The surgeon and the insurance company agreed with me that if this man could regain his activity, unhealed areas would be benefited and other health problems improved.

Impressions were taken, a four-inch heel elevation made to accommodate the shortness and the inside contour of the shoe was constructed to conform to the remaining parts of the foot, while the outside visible part of the shoe was made to duplicate the other shoe (normal).

The staff was very much interested in this unusual appearing shoe and especially since it worked out so well. The surgeon was also appreciative of the gait rehabilitation help which was given the patient. The article by Dr. H. J. Blass[1] was very helpful and opportune.

* Personal Contour Shoe Co., Haverhill, Mass.

This is a segment of our work in which we should become more active. As a result of this case, the surgeon in charge asked me to lecture to the physical therapy department on gait rehabilitation. I also designed a movable four up-step platform, and four down-step with railing, in order to help train patients in the use of stairs.

In both of the above cases, the contour shoe, together with the desired corrections, proved to be a very simple solution for the problems at hand.

515 E. Howard St.

Reference

1. Gait Rehabilitation After Foot Casting, Journal of the A.P.A., Vol. 48, p. 153, April 1958.

UNUSUAL COMPLICATIONS IN ROUTINE SURGERY

A Case Report

RAYMOND B. HARRIS, A.B., D.S.C.
Reseda, California

A WHITE female was referred to this office on April 1, 1958 with a complaint of "fungus nails that hurt and calluses on soles that do not hurt." Patient had no previous professional care but, had endured her complaint for about 10 years.

Patient is 44 years old; weighs 170 lbs. and is 5'4" tall. About one and a half years ago she was treated for a "borderline anemia" (patient quoting physician's terminology) but did not continue treatment beyond a few weekly injections due to disappointment in the treatment. Otherwise she appeared to be in good health.

Inspection of the areas of complaint revealed bilateral onychogryphosis with yellowish discoloration under the right hallucal nail. The lateral nail borders were tender to digital pressure. There was an accumulation of callus material and debris under both great nails. She was instructed to return home and soak both feet in pHisoHex®[1] solution and to use an orange wood stick to remove debris. It was proposed that a complete examination would be done at the next visit after as much debris as possible was removed.

On Saturday, April 12, a complete examination was made of both feet and x-rays were taken in both dorso-plantar and lateral positions. The patient complained of extreme tenderness at the tibial border of the right hallucal nail, onychocryptosis being evident here. After sterile prep the digit was anesthetized at its base with 1% procaine solution sans epinephrine. The offending portion of nail was removed and a sterile medicated dressing applied.

At 8:15 A.M. the next morning, April 13, the husband called the office to report that the toe was "swollen, red, warm, and red streaks were running up the leg." Patient was seen an hour later and examination of the right hallux showed that the digit was truly edematous, erythematous, and warm in comparison to the surrounding area and the contralateral toe. There were red streaks extending proximally to the level of the ankle joint. Over the dorsal aspect of the 1st metatarsophalangeal articulation there were numerous (8-10) vesicles about the size of a pinhead. Patient's temperature was 98.8° F. and there was no tenderness at either the popliteal or inguinal lymph nodes.

This condition was diagnosed as an allergic reaction to the anesthetic. Previous questioning had brought forth the fact that the patient had received local anesthetic orally and had no reaction. At this date the patient remembered that she received an injection of Combiotic®[2] almost two years ago and had a reaction at the site of the injection. Patient claims to be allergic to penicillin also.

Fifteen minute soaks of aluminum acetate were ordered every 2 hours and patient instructed to remain in bed and elevate leg. She was also instructed to call if the condition progressed or did not subside. On the following day, 5/14, patient tele-

®[1] Winthrop Laboratories

®[2] Pfizer

phoned to report that toe "seems completely better."

The next day the patient was seen in the office and examination of the hallux showed no involvement. At this visit a discussion of the original complaint and review of findings was made with the husband present. From the history of chronic inflammation and clinical appearance of the right hallux and x-ray correlation, a presumptive diagnosis of osteomyelitis was made for the distal phalanx of this digit. There was also osteoarthritic spurring at the medial condyles of both distal phalanges of the halluces. Surgical intervention was advised to effect a nail avulsion, matricectomy and condylectomy for the left side. A partial phalangectomy was advised for the right hallux to also include metricectomy and nail avulsion. The patient was informed that a specimen of bone would be sent to the laboratory for examination and culture.

Hospital reservations were made and the patient was placed on a preoperative routine of daily pHisoHex soaks. An Rx for Bivam®[3] was given for the patient to take t.i.d.

Patient was admitted to the hospital and routine orders for presurgical lab and preparation were given. Significant findings were: acetone 2 plus and WBC 17,400.

On the basis of the two plus acetone, white count and a previous history of easy bruising, the surgery was cancelled for the next morning.

Further questioning together with resident physician revealed that the patient had been on a self-imposed diet for several months and that during the week prior to surgery had decided not to eat at all because she wanted to lose weight quickly. The patient described the typical diet she followed: Morning—half grapefruit, coffee; Noon—hard boiled egg, 1 raw carrot, coffee; Evening—slice of lean meat, 1 vegetable, coffee.

Her husband was questioned separately and he verified the diet. He also stated that she drank over 15 cups of coffee per day. At times he had noticed her eating candy when he was not supposed to be looking.

A glucose tolerance test was ordered for the next morning. A urinalysis and a CBC were ordered for the afternoon. Results:

Glucose Tolerance Test

Fasting	100
½ hr.	200
1 hr.	199
2 hrs.	167
3 hrs.	99
4 hrs.	71

It was felt that the absence of acetone represented decreased fat oxidation;[1] the patient having been on a full diet the previous day. The glucose curve represents the picture of previous low carbohydrate intake or starvation state.[2] The increased hemoglobin seemed to be due to dehydration and resultant hemoconcentration.[3] Although the patient did drink coffee excessively, the diuretic action of the drug would not allow the absorption of water. Surgery was rescheduled for the next day.

Prior to surgery, a CBC was repeated and the only change was a drop in the white count to 13,800. Surgery completed with patient in good condition during and on awakening. Surgery performed was L. Hallux: nail avulsion; matricectomy; resection of medial condyle at base of distal phalanx. R. Hallux: removal of nail plate, nail bed and total matricectomy; resection of distal ⅔ of distal phalanx with specimen sent to lab for path report and culture.

Post-up orders: 1. elevation and cradle, 2. no ambulation, 3. Truozine®[4] tab. ii q.6.h., 4. Demerol®[5] 100 mg. stat. and prn, 5. Nembutal®[6] gr.iss h.s. s.o.s., 6. Diet to

®[2] U. S. Vitamin Corporation

®[4] Abbott ®[5] Winthrop Laboratories
®[6] Abbott

tolerance. Ordered exercise of rotating ankles for next day.

On first day following surgery patient was comfortable and eating well. She reported that she had bent right big toe during the early morning and heard a "pop." This was investigated to rule out suture rupture and also avulsion of the Extensor Hallucis Longus tendon. On removal of the dressing the sutures were found to be intact. A sterile redress was done. The action of the tendon was checked passively and then actively on a controlled basis and found to be intact and functioning properly. The exercises were ordered stopped.

2nd day—rechecked tendon. This was found to be as above.

3rd day—rechecked tendon. Ordered bicycle exercises.

4th day—TPR as expected; patient eating very heartily; beginning to "find a taste for water."

5th day—patient progressing satisfactorily. Ordered final CBC for the next day.

6th day—patient doing well. The blood work shows a WBC of 8,800.

7th day—Patient discharged from hospital. She was instructed to return to the use of Bivam as before surgery.

10th day—Sutures were removed, edges show good approximation. A sterile redressing was done.

12th day—A phone call from the hospital's lab reported that the bone submitted for culture showed growth of Staph. albus

Urinalysis

acetone 0
reaction 7.0
epith. cells many
other factors about the same as before
CBC: the only change was a slight reduction in the white count to 16,800

that was non-hemolytic and coagulase negative. Instructed lab to proceed with sensitivity.

14th day—Office visit for redressing. Patient given hydrotherapy 95° for 20 min. A dry sterile dressing was applied and patient given permission to return to work on 16th day. Referred to internist for complete exam.

18th day and 26th day—redressings were again performed and at the latter visit no dressing was applied as healing was complete.

29th day—the lab submitted a report on the sensitivity tests It was found that the organisms were resistant to penicillin, chloromycetin and sulfa drugs. They were sensitive to the broad spectrum antibiotics and especially sensitive to Spontin®[7].

Apparently our use of Truozine aided our efforts, or the patient recovered in spite of our efforts. No doubt the surgical intervention to "clean out" the area and the subsequent anabolic therapy played the major role in effecting a reversal of the osteomyelitic state.

The pathologist's report was perifocal cellulitis, based on the nail and nail fold tissue.

The following report was received from the internist to whom the patient was referred:

"Mrs. D. was asymptomatic when I saw her, and revealed no abnormalities on detailed physical examination other than the presence of moderate obesity. Laboratory studies showed a normal urinalysis, hemoglobin, hematocrit, and white cell count, as well as normal cervical cytology. Her hemoglobin, particularly, was 13.0 gm., which corresponded with a hematocrit of 40, in contrast to the reports of her hospital studies, in which there was a mild elevation of hemoglobin. I agree that the elevated WBC seen during hospitalization could well have been due to osseous disease alone, and her glucose tolerance test which showed a high one-half hour peak, but a normal

(Continued on Page 85)

®[7] Abbott

JOURNAL
OF THE
AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

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3301 Sixteenth Street, N.W., Washington 10, D. C.
A. RUBIN, D.S.C., Editor

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THE PRESIDENT'S PAGE

FUND FOR THE ADVANCEMENT OF PODIATRY-CHIROPODY EDUCATION

You must have been proud of the kit and brochure you received! It is a fine example of what the A. P. A. and its committees are doing for you and your profession. All of us owe a special thanks to Dr. Harry Horowitz and his committee for this outstanding effort.

You must realize the gravity of the situation. The chips are down. We must help ourselves before others can be motivated to help us. Did it ever occur to you that if we do not aid ourselves by contributing to this fund, then in the eyes of others, you place your profession in the position of the indigent who does not help himself. When the leaders of your profession appeal to foundations or government agencies for financial aid, their first question is . . . what have you done to help yourselves? Remember, you may earmark your contribution for a certain college, if you desire.

This is a program in which you can have the utmost confidence. Much thought and effort preceded the launching.

In conclusion, may I emphasize that the need for funds is not peculiar to our profession. Other professions are meeting this challenge. I know podiatry-chiropody will fulfill its obligation too.

G. E. Guenzler, D.S.C.

ARE THESE DUES NECESSARY?

About this time each year many of us receive from our State Society office, our annual dues notice. These are normally due and payable on or before June 1st and we are technically delinquent if not paid up by that date. However, a resolution of our House of Delegates requires that delinquents be removed from membership rosters and denied membership privileges as of September 1st.

As we make out our checks it is not unnatural for us to ask "Why?" and "for what?"

A great many working people pay dues to a trade or industrial union for the obvious individual economic gains and for group social gains only achievable by the cohesiveness of the members. (And their annual dues most frequently exceed those paid by members of a profession to their associations.) But these

are not the reasons a professional belongs and pays dues to his professional societies and associations, although these may incidentally accrue.

A practitioner of a health profession has a primary responsibility to his patient and the general public. His patient, to be helped and served properly, must know that his doctor is well qualified in a profession that has earned and merits general public confidence. To accomplish this requires not only initiative and activity by the doctor as an individual, but planning and action as a group through an organization.

What are some of the programs a doctor's dues do or should provide? Aside from "housekeeping" functions our programs are basically related to Professional Education and Public Education.

Public Education programs require the collection, preparation and dissemination of information to all peoples. In addition to the general public, some others are service groups, other professional (especially health) groups and individuals, public and private agencies, government offices and officers and legislators. To serve our patients and the general public we must be prepared to supply information to all. We must arrange for opportunities to present accurate, factual evidence. We must accept responsibility for educating, informing, and assisting other professional associations.

Professional Education programs should assure a continually growing number of competent graduates from superior schools and enable the practitioner to keep abreast of advances and increase his professional competence.

Our periodicals must report the best and current technical professional information. Our meetings must present the most informed and most informing speakers. Our schools cannot be superior without our financial support. Young people must be acquainted with our profession before the select will select our professional area for service to mankind.

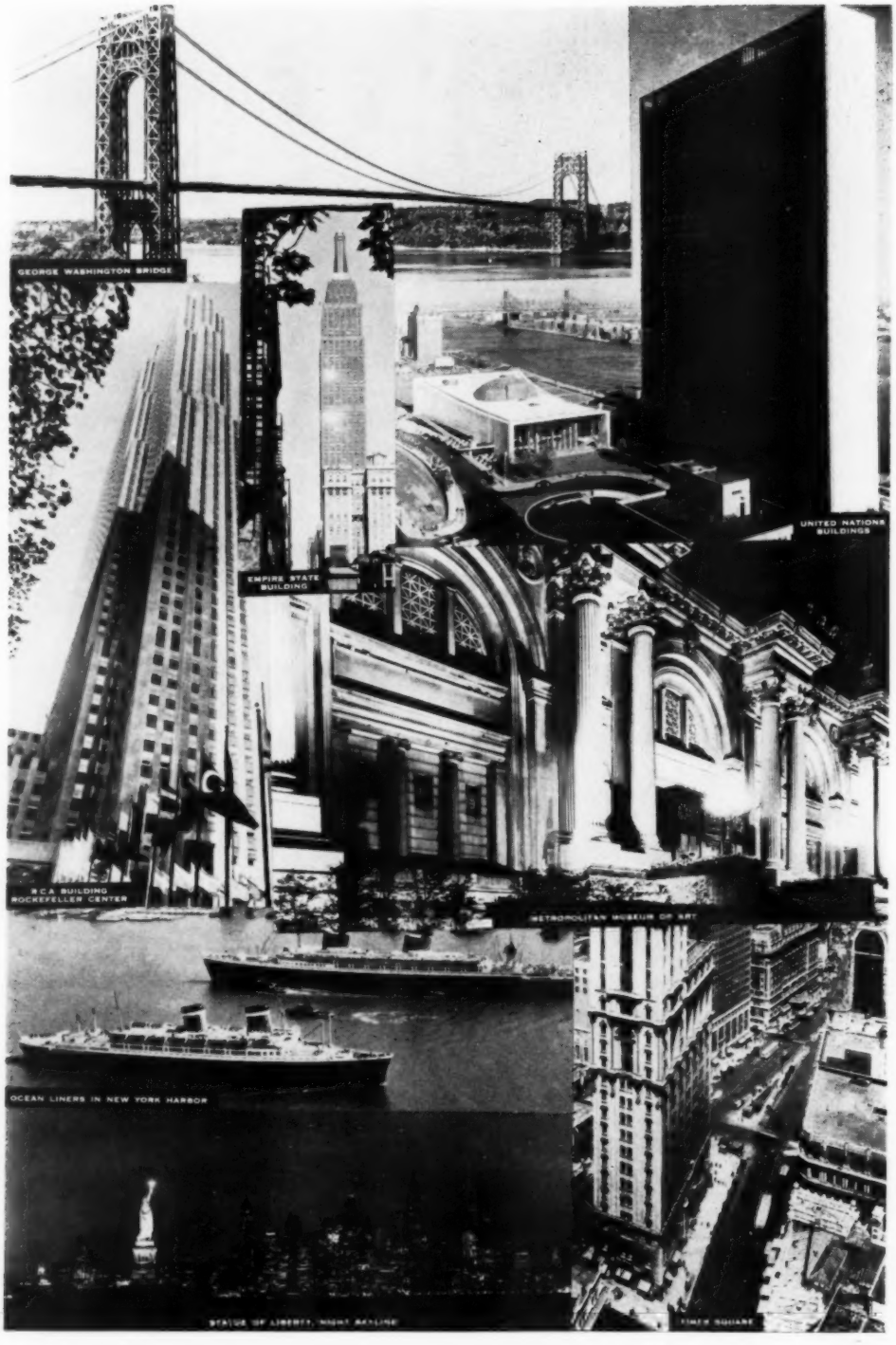
Our dues now provide only the beginnings of programs in these areas. Many other professions have greater per capita annual dues and larger memberships. Our responsibilities to our patients and communities require us to make our minimal contribution (dues) to our association larger.

Recognizing that the first need is to our Professional Education, the Executive Council of our Association is recommending to our House of Delegates an annual increase in dues of $10.00. This is to retain a professional educator to assist our Council on Education, to administer our guidance program and "Fund for the Advancement of Podiatry-Chiropody Education." The increase is to provide for the personnel and programs in their area and also to assist in the gathering of information and publication of a brochure presenting the areas in which our profession contributes to the public welfare.

Dues and more dues are not only necessary but represent the extent to which we are willing to accept professional responsibility for our patient, our community and our nation.

FOOT HEALTH WEEK AND YOUTH FOOT CARE WEEK

Foot Health Week is May 8-15 this year and is again sponsored nationally by the American Foot Health Foundation. Youth Foot Care Week is October 19-24, 1959. It is not too early to start planning for the latter, it is late for the former. For information on both programs write to Dr. Sidney Hirschberg, 107-07 Continental Avenue, Forest Hills, New York.


GEORGE WASHINGTON BRIDGE
EMPIRE STATE BUILDING
UNITED NATIONS BUILDINGS
R C A BUILDING ROCKEFELLER CENTER
METROPOLITAN MUSEUM OF ART
OCEAN LINERS IN NEW YORK HARBOR
STATUE OF LIBERTY, NIGHT SKYLINE
TIMES SQUARE

FORTY-SEVENTH ANNUAL MEETING

August 27-September 1, 1959

New York City is prepared to welcome you and your family to our 1959 Convention.

The composite picture on the opposite page is made up of some of the sights you will be seeing: The George Washington Bridge, spanning the Hudson River, is the second longest suspension bridge in the world and connects with the New Jersey Turnpike and other first class highways; the United Nations Building, where over 3,500 international civil servants work; the tallest building in the world, the Empire State Building, known as the Colossus of Manhattan; the RCA Building in Rockefeller Center towers seventy stories above the Lower Plaza where the flags of the 79 member nations of the United Nations are flown; the Metropolitan Museum of Art will be floodlighted as shown in this night view, as New York City's "Salute to Seasons"; New York Harbor, the Gateway to America, welcoming the world to the shores of the United States; America's official hostess, the Statue of Liberty, glowing brightly against the sparkling skyline of the city; Times Square, the Crossroads of the World, where the finest in entertainment awaits you.

The Waldorf-Astoria, our Convention Headquarters, will provide all the facilities to make your trip to New York comfortable and enjoyable, including extra folding beds free of charge for children under twelve years of age.

The New York State Podiatry Society, as host, is planning a program of scientific sessions and conferences which will be outstanding. Also, a well-coordinated program of social events and functions are being planned along with theatre parties and sight seeing.

The House of Delegates will meet Thursday and Friday, August 27th and 28th, with a final session on Monday morning, August 31st. The Scientific Sessions will begin Saturday, August 29th, and conclude on Tuesday, September 1. The President's Reception and Ball will be held Sunday, August 30th. The Official Banquet will take place on Monday evening, August 31st.

The theme of this Annual Meeting will be "Health and Recreation Education for America's Youth." It is well recognized that good health and recreation are fundamental to the full development of the total capacities of our youth. Before this concept can be useful it is necessary that youth itself acquire and practice good habits in health and recreation.

A conference on this theme will be arranged which will consist of a series of panels to consider:

1. What are good Health and Recreation habits?
2. How to motivate the individual youth to good Health and Recreation habits.

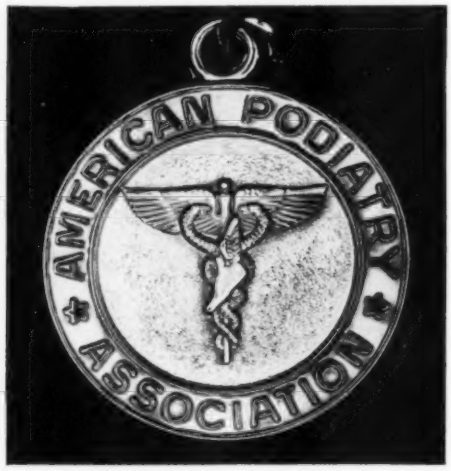
These panels will be composed of outstanding leaders in the following fields: Health (general, dental, foot), Health Education, Recreation, Community Planning, Service Clubs, Parental Groups, Youth Groups, Motivation Psychologist, Public Education and other related groups. We expect an outstanding national leader in the field of health and/or education to be the Chairman of this Conference.

The Executive Council Convention Committee is composed of Dr. Jonas Morris, Chairman, and Drs. L. B. Thompson and Earl Kaplan. The General Chairman of the Committee on Arrangements is Dr. Milton Wolfson. Associate Chairman is Dr. Lester Bluhm, Coordinator is Dr. Raymond K. Locke. Co-Chairmen of the Scientific Program Committee are Drs. Joseph Nemiroff and Seymour C. Frank, with Dr. Richard Schuster as Consultant. Chairman of

the Hall of Science Committee is Dr. Oscar Scheimer (see details below). The Ladies' Program is under the direction of Mrs. Martin Brooks.

Subsequent issues of the Journal will bring you further details on the 1959 Annual Meeting.

1959 HALL OF SCIENCE



Medal Awarded to Hall of Science Exhibitors

The 1958 Annual Meeting in Washington presented over forty outstanding and informative Scientific Exhibits, many of which attracted nationwide interest. The Science Theatre commanded an audience all day long with a series of carefully selected films.

This year even greater interest is anticipated with the theme of "Health and Recreation Education for America's Youth." (See page 79 for details on this theme.)

Gold, Sterling and Bronze Medals, as illustrated on this page, will be awarded in each of the following categories:

1. Individual (sponsored)
2. Individual (unsponsored)
3. Education and Information
4. Institutional (schools)
5. Junior and Senior High School—For outstanding Health or Science Fair exhibits on foot health.

All members are invited to present their research, experiments and demonstrations to the profession through a Scientific Exhibit. We also anticipate and solicit exhibits from the following sources: The Colleges of Podiatry-Chiropody, The State Societies, Specialty Groups, Women's Auxiliary, Allied Professions, Hospitals and Clinics, Industrial and Pharmaceutical concerns, the various Armed Services and the various State and Federal Governmental agencies.

This year we plan to have a Hobby Lobby Exhibit. Many requests have been made for this feature, so prepare your exhibit and plan to "Lobby" for your "Hobby."

For information and applications for Scientific Exhibits, write to Dr. Oscar Scheimer, Chairman, 10 Fairview Avenue, Westwood, New Jersey.

WASHINGTON REPORT

IN THE first two weeks of this first session of the 86th Congress, the legislators got off to a running start by introducing 2,852 bills in the House of Representatives and 497 bills in the Senate.

President Eisenhower's budget gives the Department of Health, Education and Welfare more money to spend next year than at any time in its six years of existence. Of a total budget of 77 billion dollars, 3.14 billion, 89 million more than the current year, is earmarked for this department.

HEW's budget includes grants of 2 billion for public assistance; an increase in funds for Food and Drug Administration to implement the new law dealing with the use of chemical additives for foods; provides 1 million for a new program for grants to schools to train teachers for the mentally retarded; expands the program for vocational rehabilitation with an additional appropriation of 8.2 million and a goal of rehabilitating 90,000 persons; grants 1 million for training of public health officials; 245,000 for the study of staphylococcal infections that have plagued hospitals; 200,000 for air pollution studies and 805,000 for studies of the effect of radiation on humans.

The spending of funds voted HEW by Congress for construction projects during the last session to boost the sagging economy will overlap this year's proposed budget. The President's plan for balancing the budget includes holding down appropriations for new construction grants for hospitals, health research facilities and sewage disposal plants. Secretary Flemming said that this budget will take care of the need for hospital beds resulting from the growth in population, but will not cut into the backlog of needs. He also stated that the proposed program of grants for the control of tuberculosis and venereal diseases would be trimmed since it was felt that the states could carry a heavier load in combating the two diseases.

Veterans

Since November 1, 1958, you have been able to purchase the new increased disability income coverage on your National Service Life Insurance. For details, contact the V.A. office in your city or write to the address where premiums are mailed.

NIH 7519: Public Health Service is satisfied that this new synthetic is a superior analgesic but trials are continuing, to determine addiction properties of this coal tar derivative known only as NIH 7519.

In Brief: Health legislation activity was greater in the House last year. It is expected that the Senate will lead the way this year with comparatively early committee action supporting international medical research and attention will be given to the fiscal plight of medical schools. Three House members and one Senator have introduced bills to provide basic and major medical coverage for government workers and their families, with the U. S. bearing more than two-thirds of the cost. A 51-page report, published by the National Cancer Institute, which gives brief summaries of outstanding investigations supported by National Cancer Institute grants between January, 1957 and March, 1958, is available (PHS Publication No. 623—25 cents, from Superintendent of Documents, Washington 25, D. C.).

Promises. Bad promises are better broken than kept.—*Last Public Speech, April 11, 1865.*

—*Lincoln*

INCOME TAX

Henry Kent, C.P.A.

TYPICAL EXPENSE ITEMS WHICH ARE OFTEN OVERLOOKED

(Editor's Note: The author has requested that we do not publish his address, but he will personally answer letters received in the Journal offices regarding his series of papers on income taxes. "Taxation on Capital Gains and Losses" will appear next month.)

ALTHOUGH the "Ides of March" are now a thing of the past for individual taxpayers, we are still faced with filing and paying the balance of our income tax on April 15th. All of us are aware that taxpayers engaged in a profession are entitled to deduct from their Gross Income the current operating expenses of their practice (the so-called Trade or Business Expenses) to arrive at their Net Income. Among those expenses are salaries of employees, rent, telephone and a host of other obvious operating expenses. This article will discuss expenses incurred by the average professional taxpayer that are very often overlooked.

Bank Charges – If you use a special checking account in your practice, the average monthly charge is 50 cents or $6.00 per annum and each check costs 10 cents. If you pay about 40 checks on the average per month, your total annual charge will add up to $54.00. Regular checking accounts also have bank charges and should not be forgotten. Telephone–Of course, you can deduct your monthly telephone and telephone service but what about outside telephone or home telephone calls to patients and to your service? If you make twenty outside telephone calls per week on the average in connection with your business (at 10 cents per call), you will be entitled to an additional $100.00 (based on 50 weeks) of telephone expense deduction. Car Expenses–If you use your car professionally, you are, of course, justified in deducting the maintenance, insurance, gasoline and depreciation of your automobile. If the car is only partly used in your business only a proportionate part of the expenses are deductible. Here is a list of business car expenses for which you very rarely receive a bill or pay by check. Parking (including parking meters), car washings, tolls, minor repairs and small replacements, occasional cash purchases of gasoline (outside your garage or credit card) and tips to parking lot attendants. If you are entitled to deduct your car expenses or a proportionate part thereof as a business expense, you may have incurred all or some of the above-listed deductible expense items. Depending, of course, on the circumstances, such minor car expenses sometimes add up to $200.00 to $250.00 per year. One word of warning–driving to and from work is not deductible.

Cleaning of your office–The purchase of cleaning materials is usually paid for by cash and is deductible as part of your cleaning expense. Taxis and carfare in connection with your profession are very often overlooked. Here again, going to and from work is not deductible but other transportation expenses in your business in addition to your car expenses are allowable. Year-end expenses such as tips to mailmen, porters, elevator men in your office building, etc., in your professional practice are sometimes forgotten.

Another business expense item which is not often taken into account is postage. One way of computing the postage expense is multiplying the average monthly number of business letters mailed, times the postage, and multiplying the result times 12 to arrive at the annual deduction.

It is important for a taxpayer claiming business deductions on his tax return to establish proof of the correctness of the claimed amount and also its connection with his business. In addition, the claimed

expense must be one that is both ordinary and necessary in his business or profession. The burden of proof rests upon the taxpayer.

In the verification of deductions for expenses, problems constantly arise as to deductions based on a substantial number of small items which often are not susceptible of complete substantiation by documentary evidence. Some of the above-mentioned expenses are typical of such items. A complete daily or weekly record indicating the expense by nature, date and amount is helpful in establishing proof, especially when the expense is reasonable. Averaging on items like postage, telephone, etc., if based upon a reasonable assumption, will help to have the deduction allowed. Keeping of cash slips from stores, parking lots, gas stations, etc., is an excellent idea to corroborate some of the amounts claimed.

One important fact to keep in mind—prepare your tax return early and carefully. Don't wait until the last day. In this way, you will be able to recall many expense items which are frequently overlooked. You will be surprised, however, by the total amount of additional deductions to which you are entitled.

BUSINESS DEDUCTIONS FOR INSURANCE, ACCOUNTING AND LEGAL EXPENSES

Although the term "Trade or Business Expenses" does not appear named as such, on the federal income tax return, it affects many of the deductions of all classes of taxpayers. Its application to a taxpayer operating a store, a factory or any other business enterprise is obvious and it, therefore, affects most corporations, partnerships, and businesses owned as individual proprietorships.

Expenses operating a profession come also within its scope. This article will discuss only two types of business expenses of taxpayers engaged in a profession, namely, insurance and professional fees.

Perhaps a few words about expense deductions in general are indicated here. The federal income tax law allows only two types of expense deduction for individual (non-corporate) taxpayers—namely, business expenses and non-business expenses. Among the "non-business" deductions are contributions, medical expenses, certain taxes, etc., and many types of expenses of individuals that do not qualify as being paid or incurred in carrying on a trade or profession but are nevertheless deductible under this group of expenses. Expenses such as interests on a personal loan, an accounting fee for the preparation of a tax return of a taxpayer who does not carry on a business, real estate taxes on a personal residence and a host of other similar types of expenses are of such a nature. Of course, certain expenses are not deductible at all —such as upkeep of an automobile for personal use only, repairs on a personal residence, etc.

Business expenses are the normal, current cost of operating a business or profession. Business Insurance Expenses and legal and accounting fees are found among this group of deductions.

Insurance Expenses:

Insurance premiums paid in connection with carrying on a professional practice or covering property used in the profession are deductible as business expenses. The following are the most common types of deductible insurance expenses of professional men:

Workmen's Compensation Insurance on employees, water, fire, theft and malicious damage on business property, malpractice insurance, public liability insurance, employee's group hospital and medical insurance, automobile insurance on a car used professionally (or a proportionate part thereof), overhead disability insurance premiums that would reimburse a professional

man the operating expenses of his office incurred during a prolonged period of disability due to injury or sickness. However, deductions for premiums on disability insurance which provide indemnity payments regardless of office overhead are not deuctible. Premiums on Life Insurance are not deductible. Insurance premiums on personal property are also not deductible. However, where personal property is used partly for business purposes, a proportionate part of the maintenance and insurance expenses is deductible. For example, a doctor might use several rooms of his home in his practice.

When is an expense deductible? That, in turn, depends on the accounting method used consistently by a taxpayer. Two different methods are perhaps most frequently encountered—the cash method and the accrual method. Briefly, in the cash method, the income is that actually or constructively received and the deductions are for expenses actually paid out. In the accrual method of accounting, the income reportable is that due (even though not received) and the deductions are amounts for which you are liable (even though not paid.) A change from one method to the other requires the approval of the Internal Revenue Service and is generally difficult to obtain. Most doctors and other professional men are on a cash method of reporting their income and expenses.

Business insurance is sometimes written for a period of more than one year. Such premiums paid in advance for a period of more than one year are generally not deductible currently (even by cash method taxpayers) because the benefits of such expenditures are considered to extend beyond the tax year and deductions have been limited to a pro rata amount for each tax year covered by the policy. However, a recent court decision has somewhat departed from this well-settled policy of the Internal Revenue and has ruled that where the cash basis taxpayer has followed the *consistent* practice of charging all business insurance premiums to business expenses in the year of payment (regardless of length of insurance coverage) such premiums are currently deductible. (Waldheim Realty and Investment Co. vs. Commissioner—Eighth Circuit 1957.) Based on this decision, proration of business insurance premiums may not be necessary by a cash basis taxpayer who has consistently followed the practice of charging premium payments to current expenses. Accrual basis taxpayers are required to prorate insurance premium payments.

The above rule, applicable to prepaid premiums, does not apply to premiums paid on policies written for only one year and extending beyond the current tax year. They are deductible as current business expenses in the year paid by cash method taxpayers.

Accounting and Legal Fees:

Accountant fees for the preparation of tax returns, representation of a taxpayer before the Income Tax Bureau and for general accounting services rendered are deductible by a taxpayer engaged in business or a profession as a business expense. Accountant fees for filing tax returns are also deductible as a non-business expense (deductible on Page 2 of the individual income tax return under miscellaneous) by a taxpayer not engaged in business.

Similarly, legal fees paid in connection with litigations are deductible as business expenses where the litigation is directly connected with or proximally results from the taxpayer's business. Examples of such expenses are for the collection of a business bad debt, defenses against claims (including the amounts paid in settlements of such claims), if they arise in connection with business transactions, legal expenses in defense of malpractice charges. Legal expenses incurred in connection with tax de-

termination are deductible if it can be shown that such expenses were connected with the taxpayer's business. Actual litigation or success is generally a prerequisite to a deduction. It is enough if the situation is one in which customary business practice calls for the retention of counsel.

The following legal expenses are among those not generally deductible: Legal fees incurred in connection with most alimony suits, closing fees on personal residences and non-business transactions. Attorney's fees paid or incurred for the acquisition of a business, or good will or any other capital asset are not currently deductible and should be added to the cost of the property so acquired. Legal fees paid in connection with making a will are also not deductible.

Legal and accounting fees, if allowable as a business deduction, are deductible by accrual method taxpayer in the year incurred and by cash basis taxpayer in the year paid.

Freeman

(Continued from Page 61)

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Harris

(Continued from Page 75)

three-hour level is characteristic of a normal response in a person who has had inadequate carbohydrate intake prior to testing. Mrs. D. was placed on a weight reduction diet, and no further therapy appears necessary.

7537 Reseda Boulevard

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Mazzaglia

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TECHNIQUES IN FOOT SURGERY

L. R. McCAIN, D.S.C., F.A.C.F.S., and N. J. PICKETT, D.S.C., F.A.C.F.S.
Editors, Publications Committee, A.C.F.S.

Illustrated case reports and discussions, suggesting approaches to podiatric surgery, from the files of the American College of Foot Surgeons.

Several inquiries have been made by chiropodists not acquainted with the American College of Foot Surgeons as to how the material for these various cases is collected, condensed and made presentable for publication.

Each candidate for fellowship in the American College of Foot Surgeons is required to file 75 case histories. The requirement for associateship is 25 case histories. The college has a case history report form which is used by the candidates in fulfilling this portion of the requirements for fellowship or associateship.

From the collections of these case histories, the editors of this column select instructive and interesting histories. The information from the case history report form is re-constituted in narrative form.

Copies of these case history report forms are available through the office of the Secretary of the American College of Foot Surgeons.

Regarding Operation for Hallux

Comment: This case history is being presented not only because of its interest but as a reminder that very frequently we are called upon to attempt surgical correction on deformities which have previously been operated on with mediocre or poor results.

Patient: Female, age 51, was seen at the hospital on May 12, 1956 for the correction of a surgical accident which was a result of previous surgery for a Hallux Valgus deformity. The original surgery was performed on the patient on March 24, 1956. At that time, the area involved healed without any unusual manifestations. However, shortly after the original operation x-rays were taken which revealed an area of spicule fracture on the medial side of the head of the first metatarsal. The involved bone appeared to be adhered at its proximal portion but because of muscular pull appeared elevated distally. It was located distal to the condylar ridge along the shaft of the metatarsal.

Urinalysis: specific gravity 1.025, pH-4.0; epithelial cells, occasional; occasional crystal of calcium oxalate, albumin—negative; sugar—negative.

Blood Chemistry: Clotting time—4 minutes; bleeding time—1½ minutes; W.B.C.—7,000; R.B.C.—4,800,000; Hemoglobin—14.0 gms; Kahn—negative.

Preoperatively the patient was given by the anesthesiologist—Nembutal®[1] 1½ gr., Atropine®[2] 1/150 grs. Xylocaine HCL®[3] 2% plain, in the amount of 12 cc, was administered as the anesthetic.

A six centimeter semi-elliptical incision was made medial to the extensor hallucis longus tendon, care being taken not to impose the incision over the previous scarred area. The skin was reflected and the subcutaneous tissue was reflected by sharp dissection. The joint capsule was not molested in that the spicule was found to lie proximal to the capsular attachment. The spicule of osseous tissue was excised with osteotome. The subcutaneous tissues were reapproximated and retained with six single interrupted sutures of 00 cat gut. The skin was closed with 11 single interrupted sutures of 000 dermal.

Post-operatively the patient needed little sedation. The sutures were removed on

®[1] Abbott
®[2] Parke-Davis
®[3] Astra

the 25th day of May and the patient was seen again on June 5th at which time the patient was free of pain, deformity and was dismissed.

SURGICAL REMOVAL OF MULTIPLE FRAGMENTS OF THE TUBEROSITY OF THE NAVICULAR

A FEMALE patient seen at the hospital had stepped on an uneven stone three days previously. The father thought she had a sprain. Home treatment bandage was intolerable. There was extreme tenderness and swelling over the area of the tuberosity of the left navicular.

Roentgenograms indicated that there were multiple fragments of the tuberosity of the left navicular.

Urinalysis was normal. Blood chemistry for sugar was 90 mgs. Blood count findings: Hemoglobin 93%, W.B.C. 7,500, R.B.C. 4,500,000.

The patient was given Daprisal®[1] tabs. two, and Pentobarb.®[2] gr. 1 as pre-operative medication.

After aseptic procedure, anesthesia was effected by 6 cc. 2% Procaine®[3] with 1/50,000 epinephrine and 150 TR units Wydase®[4] per 50 cc.

Operative procedure was as follows: A linear incision approximately 5 cm. long was made directly over the navicular parallel to the plantar line of the foot. The skin was retracted and bleeders were tied off with 0000 catgut. Following the same plane, an incision was made through the fascial tissue of Tibialis Posterior, the anterior slips of the annular ligament, and deeper the cuneonavicular and calcaneonavicular ligaments. These were reflected from the bone with a periosteal elevator. Five fracture fragments were removed and the medial surface of the navicular made level with the medial cuneiform, using an osteotome and bone rasp. The deeper tissues were closed with 000 chromic catgut and the slip of the Tibialis Posterior transplanted farther down on the navicular. 000 nylon was used for closure of the skin.

The patient was given Demerol®[5] 50 mg. PRN 3 h. postoperatively.

Postoperative treatment was as follows: On the third day postoperatively the outer bandage was removed and re-dressing made. The patient was also instructed to use a crutch for walking. On the seventh day Mercresin®[6] was used, the area re-dressed and figure eight Gauztex®[7] used. On the twelfth day the sutures were removed and figure eight bandage again applied. One week later whirlpool was used and figure eight bandage applied. One week later whirlpool was used and a celastic longitudinal pad placed in the shoe. The patient was discharged one week later.

Past history on this patient indicated that she had a slightly enlarged tuberosity of the navicular previous to this injury which, from time to time, had created a painful area. The great inconvenience of a cast, plus the likelihood of an even more prominent navicular after callus formation, made surgery the method of choice.

V. Herbert Levin, D.S.C.

Comments: Although this case follows immediate trauma, many similar cases, which require surgery, may be the direct result of trauma experiences several years earlier. In fact, it is often quite difficult to rule out a primary injury.

L. R. M. and N. J. P.

®[1] Smith, Kline & French
®[2] Kremers-Urban
®[3] Abbott
®[4] Wyeth
®[5] Winthrop Laboratories
®[6] Upjohn
®[7] General Bandages, Inc.

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Neo-Cort-Dome™ Creme and Lotion (pH 4.6)

Description: Contains 0.5% or 1% micronized hydrocortisone (free alcohol) and 5 mg. per gm. Neomycin sulfate in the exclusive Acid Mantle base.

Indications: Inflammatory, pruritic and allergic dermatoses complicated with secondary infection, including sycosis vulgaris, infantile eczema, pustular acne, impetigo, infected wounds and in the following diseases threatened or complicated with infection: atopic dermatitis, contact dermatitis, pruritus ani, pruritus vulvae, lichen simplex chronicus, intertriginous seborrheic dermatitis, otitis externa and related disorders.

Zondex

Description: Zondex is primarily intended as an adjunct in the treatment and control of epidermophytosis. Our available information indicates that Zondex is effective in hyperhidrosis and bromidrosis. Zondex contains trioxmethelene and hexahydrothymol as active ingredients, is available in tablet form in hermetically sealed, plastic-lined aluminum pockets, in units of six. Accompanying each sleeve of Zondex tablets is a polyethylene bag.

Zondex tablets, placed in the polyethylene bag with the shoes and hose of the patient, effectively destroy pathogenic micro-organisms in the footwear, generally recognized as a source of re-infection.

Indications: Zondex is recommended as a prophylactic, adjunct and supplement to the professional treatment of all forms of epidermophytosis.

Advantages: Zondex is safe and produces no side effects, and is effective in destroying the spores of fungi in the environment of the feet, namely, shoes and socks. There are no contraindications.

According to available information, Zondex will effectively eliminate associated bromidrosis and hyperhidrosis.

Directions: Place shoes and socks in the plastic bag; drop 3 Zondex tablets in the bag; gather the top of the bag and secure with a rubber band; keep shoes, socks and Zondex tablets in the bag overnight; patient may wear shoes immediately after removal from bag. No airing is necessary; this procedure should be followed under the doctor's supervision and continued in accordance with his advice; for best results, all of the patient's footwear should receive this sterilizing treatment.

Supply: By prescription in packages containing 6 tablets and a polyethylene bag with rubber band. By Gross-Padow Corporation, Mfg. Chemists, 1318 Avenue J, Brooklyn 30, N. Y.

Daprisal

Composition: Each tablet contains Dexadrine Sulfate, 5 mg.; amobarbital 1/2 gr.; aspirin, 2½ gr. (0.16 gm.); phenacetin, 2½ gr. (0.16 gm.).

Action and Uses: Daprisal has two beneficial effects on the ambulatory patient in pain or acute discomfort: (1) It relieves

the physical aspects of pain through the potentiation of its aspirin and phenacetin components by amobarbital. (2) It relieves the psychic aspects of pain because it contains the mood-ameliorating components of Dexamyl—'Dexadrine' and amobarbital. Daprisal is useful to relieve pain and the mental and emotional distress that prolongs and intensifies painful conditions such as severe headaches, certain cases of migraine, neuritis, neuralgia, rheumatism, arthritic pain, low back pain, lumbago, influenza, sinusitis, myositis, bursitis, tendinitis, toothache, traumatic pain.

Administration and Dosage: One tablet every three hours as needed. An occasional hypersensitive patient may find sleep difficult. For divided dosage, the tablet may be broken in two. *Cases requiring special consideration:* Daprisal should be used with caution in patients hypersensitive to sympathomimetic compounds or barbiturates, in cases of coronary or cardiovascular disease and in the presence of severe hypertension.

Supply: In bottles of 50 and 500 tablets. By Smith, Kline and French Laboratories, 1530 Spring Garden Street, Philadelphia 1, Pa.

Hydrisinol Cream

Description: This is a hydrogenated sulfonated castor oil cream. Water soluble, Acid pH (5.6).

Action and Uses: Indicated in the following conditions: dehydrated skin, geriatric skin, diabetic skin, detergent for allergenic skin, especially useful for fissured and callused heels, substitute for soap.

Administration: Rub into affected areas and allow to remain on overnight. This cream may be massaged into any part and washed off with water, leaving a soft emollient clean skin.

Supply: In 2-oz., 4-oz. and 1-lb. and 5-lb. jars. By Pedinol Laboratories, 152 West 42nd Street, New York 36, N. Y.

Marezine Hydrochloride

Description: Anti-emetic compound developed by the Wellcome Research Laboratories apparently free from sedative action. Usually acts within 10 to 20 minutes when given orally.

Indications: Motion sickness, nausea and vomiting of pregnancy. Postoperative vomiting. Radiation sickness. "Marezine" is effective prophylactically or when symptoms such as dizziness, sweating, nausea, or actual vomiting are apparent. When vomiting is intractable, or the oral route is precluded, injection or suppositories are used.

Administration: Treatment, 50 mg. (one tablet) 3 or 4 times daily before meals. During pregnancy the first dose is taken 15 minutes before rising. Prophylaxis of motion sickness, 50 mg. (1 tab.) ½ hour before starting a journey. Postoperative vomiting, 50 mg. (1 cc.) intramuscularly 15 to 30 minutes before anticipated end of operation.

Supply: 50 mg. scored tablets in vials of 10 and bottles of 100 and 1000. Also injectable in the form of Cyclizine Lactate Injection in 50 mg. to each cc. Ampules of 12 and 100. By Burroughs Wellcome and Company, Inc., #1 Scarsdale Road, Tuckahoe 7, New York.

Ultran

Generic Name: Phenaglycodol.

Description: Each tablet contains 200 mg. of phenaglycodol. A mild tranquilizer for use in the treatment of emotional instability, anxiety-tension states and functional disorders in which an emotional component is prominent. Tranquilization is achieved without serious side effects.

Administration: Orally. Adults, 200 to 400 mg. 3 times daily. Children, 100 mg. per 50 lbs. of body weight 3 times daily.

Supply: 200 mg. tablets in bottles of 100. By Eli Lilly and Company, Morris and Kentucky Streets, Indianapolis, Indiana.

PODIATRY-CHIROPODY ABSTRACTS

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Editors of Local, State and Regional Publications are requested to provide copies to the Chairman of the A.P.A. Committee on Publications.

THE HOOP—A THERAPEUTIC AGENT?

Irving Yale, Current Chiropody, 11:11-13, November 1958.

We have come to think of the sudden outburst of a new popular toy or sport as a fad. Many of the toys developed for children fire the imagination, allow for physical exercise, develop manual dexterity, acuteness of bodily functions and otherwise serve a useful physical purpose. The new hula hoop type of toy presents an interesting study for students of stance and locomotion.

When the hula hoop revolves about the body the feet undergo some interesting changes. The foot undergoes exercise in the forward and backward maintenance of stance which cannot be accomplished in ordinary stance or progression. The small intrinsic muscles of the foot, and leg muscles inserting into the foot, together with the proprioceptive actions and reactions, bring about beneficient results to an otherwise sedentary population.

THE SEDIMENTATION RATE AND ITS VARIABLES

Nancy Lu Conrad, Current Chiropody, 12:7-8, December 1958.

One of the tests most easily adaptable as an office procedure is the sedimentation rate of the erythrocytes. Its simplicity is not an invitation to haphazardly ignore the fundamentals of laboratory detail: many results have been incorrectly considered in the interpretation of final readings because of poor technic.

Although the exact cause of the rate of fall of the cells is not known, it is generally accepted that it is dependent upon the plasma protein ratio and probably also the amount of plasma cholesterol present. It is increased in acute infections, heavy metal poisoning, kidney disease, gout, tissue destruction whether inflammatory or degenerative, rheumatoid arthritis and rheumatic fever. It also helps to differentiate between inflammatory and noninflammatory conditions and one of its chief attributes is in following the progress of any particular case.

SOMATIC PAIN

A. Rubin, Chiropody Review, 10:14-19, October 1958, (Reprinted from Chiropody Record).

Pain is defined in the medical dictionaries as "distress or suffering." Pain denotes sharp, sometimes sudden, ache; continuous, often dull, bodily suffering." From these definitions it is clear that pain is a conscious awareness on the part of the individual suffering the pain. It is not a physical entity, but an abstract concept or idea in the mind of the sufferer. In order for the individual to recognize pain, a pain receptor must have been stimulated. Real pain then is a form of communication.

Dr. Rubin presents a review of the neurohistology and physiology of the pain apparatus for the lower extremity. This review is brought forth in the light of clinical interpretation.

Some generalizations regarding pain can be stated:

1. Sharp lancinating pains, neuralgic in character, tend to be associated with external stresses affecting nerve pathways. An example of this type is the fibrous hyper-

plasia of a neurinoma attached to a digital nerve, as in "Morton's Neuralgia."

2. Burning sensations are frequently associated with histochemical changes in the nerve pathways. These are neuritides; ischemic (anoxic) neuritis, metabolic forms (e.g. B_1 and B_{12} deficiencies, etc.), toxic neuritis (e.g. heavy metal, bacterial toxins, etc.).

3. Dull aches, hurts, and tenderness usually represent pain in the deep structures. Typical examples are: (a) the stress induced strains that produce the pain in a weakened arch, (b) the arthritides.

4. The intensity of pain reported is more directly related to the emotional stability or maturity of the patient, than it is to the pathology. This is the typical psychosomatic condition.

Pain is the first line of defense against insults to our tissues.

EXAMINATION OF THE REFLEXES

Mario V. Calligaro, J. of the Wisc. Soc. of Chiropodists, 5:3-7, Nov. 1958, (Reprinted from N. J. Chir. J.).

The examination of the neurological reflexes should be, and must be, a part of all chiropodical procedures. Skillfulness in eliciting reflexes requires much practice and must be patiently learned. The reflexes may be classified as "deep" and "superficial" depending on the condition pathways.

Dr. Calligaro discusses the Deep Reflexes, The Principal Deep Reflexes of the Lower Extremity, The Superficial Reflexes and the Pathological Reflexes.

It is remarkable how many neurological conditions can be discovered and differentiated by a simple and brief examination of the foot, ankle, and leg. It is surprising how often a patient will report minor symptoms of foot disturbances that turn out to be indications of serious neurological lesions.

AVULSION FRACTURE OF THE CALCANEUS

Irving H. Block, Ind. State Pod. J., December 1958, (Reprinted from Florida Footprints).

An avulsion fracture of the calcaneus is easily and often overlooked either because the patient or doctor or both are negligent. When there is a great deal of trauma causing an alteration or displacement of the nearby joints, or where a compound fracture of the body of the bone itself occur, the visual clinical evidence makes emergency roentgen examination a simple request. However, the posterior surface of the calcaneus may be wrenched away by a rather insignificant pull of the tendo-achilles. Unless this posterior muscle pull is eliminated the fragment of bone may further separate from the main body and slide upward causing such displacement that open reduction may then become necessary.

In all injuries of the ankle or tarsus even where violent trauma has not occurred radiographs should be made. It should be routine procedure in any heel involvement to x-ray the posterior half of both calcanea. Lateral, posterior, and oblique views will usually show off an avulsion fracture of the heel.

Quarrel not at all. No man resolved to make the most of himself, can spare time for personal contention. —*To Captain Cutts, October 26, 1863.*

—*Lincoln*

BOOK REVIEW

DYNAMIC ANATOMY AND PHYSIOLOGY

L. L. Langley, Ph.D., LL.B., Associate Professor of Physiology, University of Alabama Medical Center; E. Cheraskin, M.D., D.M.D., Professor and Chairman of the Department of Oral Medicine, University of Alabama Medical Center; Ruth Sleeper, R.N., Director of the School of Nursing, Massachusetts General Hospital. First Edition, $6.00, 719 pgs., 318 illustrations, McGraw-Hill Book Company, Inc., 330 West 42 Street, New York 36, N. Y., April 16, 1958.

This book for the first time presents in a single volume a different approach of a detailed coverage of the salient features relating to the study of anatomy and physiology. The authors state that, "In the healing arts, where anatomy and physiology are essential components, an inexorable change is taking place. Yesterday the emphasis was on structure. Today it is focused on function. Anatomy, both gross and microscopic, is now recognized, not as an end in itself, but rather as a prerequisite for the comprehension of physiology, which, in turn, is essential for the total understanding of the human body. This textbook breaks with tradition. Not only is anatomy reduced, but the study of function, that is, physiology, is at all times integrated into the broader considerations of the student's major goal."

Ranging from orientation, the nervous system, circulatory system, the respiratory system, the alimentary system, the excretory system, and endocrinology and reproduction, this collaborative undertaking by the three authors should appeal to students studying this absorbing subject and to practitioners for a refreshing and stimulating review.

"Dynamic Anatomy and Physiology" is a textbook giving a general and broad coverage of the subject. The material presented uses psychological devices that facilitate learning and remembering. The text is written so that the student only beginning the study of gross anatomy who is not familiar with the medical terms may understand it.

The profusion and appropriateness of the pictures, colored photographs, drawings (many times with sketches to supplement the photographs), indicate the thought that went into this valuable book. The illustrations are beautiful and well selected. Among the valuable illustrations are a color atlas of the human body, a photographic series of the development of the human body and photographs of human models on which the various muscles are labeled in proper position right on the photographs.

At the end of each chapter you will find summaries and reviews with questions and problems relating to that chapter. At the end of the book you will find suggested readings, references and index for further study.

In my opinion, the editors and authors have performed a masterful job of organizing and presenting the above material. Both the amount of material presented and the important new information included make this text incomparably superior to any of the ordinary textbooks on this subject. This textbook is equally suited for students and practitioners in podiatry-chiropody who wish to learn, review and to keep abreast of anatomy and physiology.

Jack Ranzer, Pod.D.

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

DERMATOLOGY AND ALLERGY

New Approach to the Problem of Epidermal Contact Hypersensitivity, J. D. Everall and E. V. Truter. Arch. Derm. 75: 428-36, 1957.

In order to establish the antigen-antibody theory of epidermal contact sensitivity, attempts were made to demonstrate the existence of antibodies in the serum, attached to the cell walls (sessile antibodies), or carried by the leukocytes. Efforts failed to demonstrate the presence of antibodies in the serum by flocculation tests in vitro, and also that antibodies able to circulate become fixed to cell walls. Consistent failure also followed efforts to show by patch tests a local passive sensitivity by interdermal injection of lymphocytes into the white cells. Therefore, existence of antibodies in epidermal hypersensitivity has not been proved, nor that there are any antibodies in the serum; furthermore, if any do exist, they certainly are not attached to the tissue cells with any degree of firmness, and are free to circulate. It is further claimed that though they may be attached to the lymphocytes, the transmissible factor found in the lymphocytes is quite thermolabile, so that it seems doubtful if these are antibodies in the true sense.

The authors present an alternative hypothesis which is that the mechanism of epidermal sensitivity is based upon the supposition that the body to protect itself from invasion by foreign substances is provided with a first-line defense mechanism consisting of migratory substances (molecules of colloid particles) capable of combining with and neutralizing the effect of foreign substances. These 'neutralizers' render foreign substances harmless by removing them from the sphere of the reaction. Attempts were made to demonstrate this by use of samples of both serum and oxalated plasma from normal and hypersensitive subjects and treating these samples with a concentrated solution of nickel chloride, and incubation for 48 hours, and then used them for patch testing. These hypothetical neutralizers were not found in plasma or serum. Their possible association with lymphocytes was not investigated. Introduction of artificial neutralizers seemed to provide evidence of the feasibility of the new theory. A barrier cream containing 50 per cent edathamil calcium-disodium provided complete protection against patch tests with a 10 per cent solution of nickel sulfate; its daily use gave a high degree of protection against suspender dermatitis. When the same was given orally the concentration of neutralizer built up sufficiently to provide protection for five subjects out of eleven, but hypersensitiveness returned when the treatment was stopped.

Prescription Writing for Dermatoses, H. Goodman. Med. Times 85: 524-29, 1957.

Symptoms common to eczema and dermatitis, diseases which comprise more than 30 per cent of all skin disorders, are described and the use of topical applications in their treatment. Dermatites are treated according to the stage of their activity: (1) the reaction to insult phase (acute); (2) the subsiding phase of immediate reaction (subacute); (3) the infiltration phase of reaction to insult (chronic). Formulas are offered for treatment of each type. Direc-

tions to pharmacists and to patients are given and also treatment of refractory cases.

The immediate reaction phase is treated by application of a limited or general modified water bath; the subsiding phase by application of a paste with low concentration (less than 6 per cent) of a chemical reducing agent; the infiltrated phase by application of an ointment with high concentration of a chemical reducing agent. Currently, antihistaminics, including the steroid hormones, are often prescribed, but all patients do not react in the same way, and side effects vary. The new hormones, such as cortisone, do afford relief to some patients, but these remedies cannot be regarded as universal substitutes for accepted principles of therapy outlined here.

Allergic Dermatitis Produced by Pathogenic and Saprophytic Fungi, O. F. Jillson. Ann. Allergy 15: 14-24, 1957.

The role of pathogenic and saprophytic fungi in causing allergic dermatosis is described, with special reference to the dermatophytes and airborne saprophytic molds, and the skin test used in diagnosis. In these tests concentration of extracts, the testing amount used, and the interpretation of skin test reactions immediately, and 4 to 6 hours later, and 24 to 48 hours later following the test are discussed. Treatment of this dermatitis consists of preventive methods, such as avoidance of molds in house-dust, feather pillows, upholstered furniture and mattresses; dehumidification; removal of woodpiles, mildewed materials and decaying vegetable matter. Self-administered dilute antigens in fixed amounts are used intradermally for desensitization —the correct amount is that which produces no local reaction of systemic flare. The extract is given twice weekly until the dermatitis has been cleared for several months, and then injections are given at intervals until a booster shot is given every 3 to 4 weeks. No response can be expected for the first 6 to 8 weeks of treatment. Because of this slowness of response, topical dermatitic therapy is given for immediate relief. This may bring clearance, but recurrence is common. Permanent control can be obtained by combined dermatitic and desensitizing treatments.

DRUGS

Sulfonamide and Antibiotic Therapy After Twenty Years, W. W. Spink. Minnesota Med. 40: 215-21, 230, 1957.

A survey is made of the accomplishments in management of infectious diseases. Prontosil and sulfonamides proved effective in treatment of hemolytic streptococcal disease but within a few years highly resistent hemostreptococcic strains were increasingly frequent. Prophylactic and therapeutic use of penicillin successfully controlled many streptococcal diseases and proved specific in therapy of pneumococcal diseases and of gonorrhea and its complications, but ineffective in syphilis. Streptococcic meningitis has greatly decreased in incidence with the advent of the sulfas, particularly sulfadiazine. Typhoid fever also has decreased considerably in incidence and mortality with use of chloramphenicol. Tetracycline drugs has helped in control of brucillosis; tetracycline drugs and chloramphenicol brings prompt and progressive improvement in cases of scrub typhus. Effective hemoprophylaxis and chemotherapy has reduced malaria from the most prevalent infectious disease to one of lesser importance. Tuberculosis has responded well to streptomycin, PAS and isoniazid.

The present problems of treatment today are: (1) Drug toxicity following sulfa and antibiotic therapy; their side effects require discrimination and caution in their use. (2) Development of drug-resistant microorganisms following use of antibiotics and penicillin; a permanent characteristic of the new strains is that they are as virulent

and invasive as the original microorganism and moreover, the strains are harbored by carriers to contaminate the environment. (3) Enteric bacilli acting as parasites in the normal intestinal tract are exposed to various antibiotics and numerous resistant strains develop, making treatment of chronic infections including those of the urinary tract increasingly difficult. Many other problems remain. The fungus diseases have resisted chemotherapy, for example, histoplasmosis. Also the whole field of virus diseases requires continued investigation of chemotherapy; since microorganisms are intimately related to the intercellular metabolism of the host, therapeutic agents have to be exceedingly specific. Finally, no infectious disease has been treated out of existence, though some have been largely eliminated. Environmental sanitation and strict public health control of food, water and milk are as essential as ever. Knowledge of prevention of disease is as important as correct management of disease with antibiotics.

Pharmacology of the Tranquilizing Drugs, R. N. Bieter, Minnesota Med. 40: 222-26, 1957.

Specific areas of the cortex are concerned with sensory discriminations; certain ones with motor activities; other areas control complex processes such as thought, judgment, learning, remembering, etc. The hypothalmus is associated with emotional behavior (anxiety, fear, anger, worry, pleasure); and other subcortical areas influence homeostatic mechanisms (circulation, respiration, digestion). There is close relationship between the hypothalmus and the endocrines which influence homeostatic regulation (blood pressure, pulse rate, blood sugar, temperature regulation). Changes in internal environment produce associated changes in emotional behavior. Subcortical structures control involuntary musculature such as smooth and striated muscles, and also modify cortical activity which in turn is modified by the cortex. Since complex behavior involves the action of sensory receptors, the effective organs, and the highly complex interactions of the nervous system, disturbance along the chain of this functional unit produces behavior changes. Tranquilizing drugs serve to modify or nullify such emotional changes.

Reserpine administered by injection or orally, in a dosage ranging from a fraction of a milligram to several milligrams, has a different effect than that of the barbitals. It does not produce a sleep pattern; it produces an antiemetic action, hypothermia, increased secretion and motor activity of the gastrointestinal tract, bradycardia, a drop in blood pressure, and abolition of pressor reflexes from the carotid area. Reserpine probably acts primarily on subcortical areas, especially the hypothalmus. Animal experimentation has shown that reserpine tends to curb reactions to anxiety and fear. Chlorpromazine given by mouth, 50 to 100 mg. several times in 24 hours, produces tranquilization more rapidly but is of shorter duration than reserpine. It has a strong blocking action against epinephrine, and acts on subcortical areas. If the dose is increased it leads to increased discharge of nervous impulses which spread to other areas and sometimes convulsions result. Other drugs, less understood as to action, are also in use. Meprobamate (Miltown, Equanil) has a quieting effect without producing fear reactions characteristic of some drugs, and produces a slight drop in blood pressure and pulse rate. An initial dose of 100 to 200 mg. several times a day relieves anxiety and gives better relaxation of muscles on one hand, and better coordination on the other. Azacyclonol HCl (Frenquel) in minute doses terminates schizoid changes (hallucinations); the usual dose is 15 mg. several times a day. Promazine (Sparine) pro-

duces the same effect as chloropromazine, in the same dosage.

These drugs are used only for symptomatic relief; they are not curative. They may have side effects: chloropromazine can cause convulsions, agranulocytosis, or obstruction of the biliary tract. Chlorpromazine and reserpine both can produce psychotic reactions. Reserpine is contraindicated in depressive states and in gastric disturbances.

Experiences with Procaine Hydrochloride, F. A. Walton. Canad. Anesth. Soc, J. 4: 66-73, 1957.

Experience has shown that intravenous procaine is a useful adjunct to treatment in various types of disease, such as certain pain syndromes, burns, fracture spine and ribs, and when used immediately following thyroidectomy and hysterectomy. It may be of value also in treatment of fat metabolism. The drug relaxes spastic arterioles and skeletal muscles, and it deposits relatively high concentrations in edematous areas which result from increased capillary permeability. Oxygenation of the capillaries reduces their permeability and edema therefore is decreased. Procaine deposition in edematous areas in some cases is sufficient to produce analgesia by acting on the fine terminal pain fibers, producing relief in musculo-skeletal derangement, as in fractured spine. When permanent relief occurs, it is due to breaking up of the vicious circle of pain—muscle spasm—more pain. The vicious circle of nerve stimulus is permeability—edema—further capillary anoxia, increased capillary permeability—edema—further sympathetic nerve irritation. Conditioned reflexes developing with prolonged pain can be controlled by use of largactil, and muscular spasm is diminished by administering mecostrin 1½ to 3 mgm. intramuscularly three times daily. Largactil used alone does not control most pain syndromes. Many conditions for which intravenous procaine has been used may be handled by other methods. Brachial block is simpler to use and a more satisfactory method of producing muscular relaxation during surgery and particularly in treatment of injured hands. It should be remembered that whereas procaine has some central effect, the greater part of its action is peripheral.

MUSCULOSKELETAL DISEASES

Injuries of the Small Bones, J. R. Regan. J. Internat. Coll. Surgeons 27: 197-208, 1957.

Use of internal fixation by use of metal (pins, screws, wires) in treatment of fractures of small bones gives a false sense of security. Conservative treatment usually brings about a good functional result. Any poor results of treatment are due to inadequate or improper anatomic knowledge, to impatience on the part of patient or surgeon, or to an inability to recognize complications and to prepare for certain sequelae. Although motion during the early period is painful, after a short period of immobilization attempts at movement should be made, and possibly the use of ganglionic blocking agents. Union of small bone fractures is slow, but soft tissue contractures develop rapidly and are difficult to overcome. Only fractures of the upper extremities are discussed in this article.

Acute Osteoporosis with Hypercalcemia, A. S. Mason. Lancet 1: 911-12, 1957.

When a raised serum-calcium level together with radiologic evidence of osteoporosis is found, the bone disorder is probably secondary to the disturbed calcium metabolism, as in hyperparathyroidism. A young woman involved in a serious accident had a fracture of the cauda equina and of the third lumbar vertebra, weakness of the right leg, paralysis of the left leg, and an affection of the bladder and sphinc-

ters. Symptoms of hypercalcium appeared within four weeks. An elevated serum calcium level and lowered serum-phosphorus level suggested the presence of a parathyroid tumor; one parathyroid gland was removed and the others examined; no tumor was found. The raised serum-calcium level was found to be associated with an alkaline-phosphatase level at the lower limits of normality, and the lowered serum-phosphorus level was accompanied by normal urinary excretion of phosphorus. X-ray evidence of osteoporosis was observed in the injured area only. The diagnosis was osteoporosis with hypercalcemia. Treatment consisted of mobilization of the patient to prevent calcium loss and hormone therapy administered and intake of calcium restricted to 250 mg. daily. Recovery followed.

RHEUMATIC DISEASES

Use of Sigmagen in the Treatment of Rheumatoid Diseases, F. W. Wittich. Rev. Allergy 11: 87-89, 1957.

The basic conservative methods of treatment of these diseases for years have been relief of pain, vaccine therapy, physical therapy (heat and exercise), orthopedic measures when indicated to correct deformity, attention to the general health, and psychotherapy. The steroids have been used as adjunct therapy. Intramuscular injections of ACTH and cortisone are no longer desirable. Cortisone acetate given orally in effective minimal daily doses (50 mg.) relieves or controls symptoms; but prednisone (Meticorten) has proved more successful. A new steroid, an analgesic compound, Sigmagen, is now used by the author in treatment of various rheumatic diseases. Each tablet contains prednisone 0.75 mg., acetylsalicylic acid 325 mg., ascorbic acid 20 mg., and aluminum hydroxide 75 mg. Thirty-two patients, most of them more than 45 years old, with various rheumatoid conditions, after a thorough physical and laboratory study, were helped by this treatment. Some with climacteric osteoporosis of decalcification received in addition to Sigmagen estradiol and testosterone. In severe cases Sigmagen was given every three to four hours, but the average case required only three to four tablets in 24 hours. These 32 patients are ambulatory and have been treated over a period of one year or less with continuous or intermittent doses of Sigmagen, with satisfactory results, and with no disturbing side effects.

RHEUMATIC DISEASES; ARTHRITIS

Rheumatoid Arthritis with Chronic Leg Ulceration, J. H. Allison and F. R. Bettley. Lancet 1: 288-80, 1957.

Six patients severely crippled by rheumatism were found to have many subcutaneous nodules; most of the ulcers appeared on the lower third of the leg on the inner or outer surface. Involvement in one patient was in the leg just below the knee and in another in the foot and toe. The earliest sign was a painful induration about 1 cm. in diameter, which within a week or two broke down to form a punched-out ulcer surrounded by a reddish flush without edema. Pain was sometimes severe. No evidence was found of varicose veins, phlebitis, or vascular stasis in the legs. The ulcers failed to respond to bed rest. Steroid therapy was the only helpful measure. Although all ulcers were granulating, grafting proved a failure. It was suggested that auto-antibodies were responsible, or the granulating ulcers might have had necrotic collagen at the base.

Relationship of Therapy with Cortisone to the Incidence of Vascular Lesions in Rheumatoid Arthritis, J. W. Kemper, A. H. Baggenstoss and C. H. Slocumb. Ann. Int. Med. 46: 831-51, 1957.

A review of necropsy reports of 52 cases of rheumatoid arthritis treated at the Mayo Clinic in 1934 is presented. Of this num-

ber, 14 patients received cortisone; 4 of these 14 developed generalized lesions of polyarteritis nodosa. None of the remaining 38 patients who received no cortisone developed these lesions. Two of the four having these lesions showed signs of hypercortisonism. There was no correlation between the dosage and the appearance of the vascular lesions. These reactions are most apt to occur in patients with hypercortisonism, but the reason for the increased susceptibility of such patients is not clear. It is suggested that the cause may lie in a relative disproportion between the supply of and need for adrenal hormones produced in these patients. Menopausal women are more prone to develop hypercortisonism than others.

Features and Significance of Hypertrophic Osteoarthropathy, J. F. Hammarsten and J. F. O'Leary. Arch. Int. Med. 99: 431-41, 1957.

Clubbing of the fingers in this disease is due to increased pooling of blood in the fingertips and therefore can be distinguished from clubbing in heart disease and pulmonary disease due to fibrous tissue. A series of 22 patients with x-ray evidence of changes of hypertrophic arthropathy were observed during a 10-year period. Most of the cases occurred in the sixth or seventh decade. The early symptoms in 17 cases were related to the joints and in 5 to the chest. Pain occurred in 19 of the patients. Clubbing occurred in all but one patient. Most of the patients showed diffuse thickening of the forearms or legs or both. The joints most frequently involved were the ankle, knee, and wrist. Eight patients had joint symptoms without chest symptoms from 1 to 57 months, usually more than 18 months; 3 had chest symptoms before joint symptoms occurred; 2 had no joint symptoms; 8 had no chest symptoms. The relationship between pulmonary neoplasm and hypertrophic osteoarthropathy is shown by the striking relief of bone and joint pain within hours or weeks following resection of the primary tumor; joint changes regressed and clubbing often disappeared. In 20 of the 22 patients a malignant lesion of the lung was present. Often such patients are treated for years for arthritis before the lung tumor is discovered.

SHOES

The Foot and the Shoe, J. R. Napier. Physiotherapy 43: 65-74, 1957.

Interpretation of shoe wear patterns is a necessary adjunct to clinical examination. The distribution of wear on soles and heels corresponds with the line of maximum weight transmission, which is chiefly posterolateral in position. The wear spreading across the foot obliquely towards the first metatarsal head then extends toward the medial aspect of the shoe beneath the great toe. Primary wear on sole and heel is caused by contact with flat surfaces during normal walking. Secondary wear is due to stresses from other activities. The uppers indicate stance and gait. When there are distortions of the shoe the long axis through the center of the tip of the shoe passes medially to the midpoint of the tip of the shoe (valgus distortion) or laterally (valgus distortion). Abnormal gait is due to muscular imbalance, for example, in peripheral nerve injury of the lower limb affecting part or all of any of the three main nerves of the leg, musculocutaneous, anterior and posterior. Where imbalance is established as a result of peripheral nerve injury, use of suitable appliances is necessary, but stiffness and contracture cannot be entirely compensated by appliances.

You cannot institute any equality between right and wrong.—*Debate, Galesburg, October 7, 1858.*

—*Lincoln*

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

ARIZONA

The annual meeting of the Arizona Chiropody Association was held in Phoenix on Saturday and Sunday, January 3rd and 4th, 1959. The following officers were elected: President, Dr. Martin Snyder; Vice President, Dr. Daniel Nenad; Secretary-Treasurer, Dr. Irwin Shapiro.

Pending legislation was discussed, and Dr. Felton Gamble, Legislative Chairman, outlined procedures for following up this legislature. A law will be introduced to curb unethical advertising in our state.

The scientific portion of our meeting under the supervision of Dr. Samuel Mason, Scientific Chairman, consisted of a series of discussions regarding physical medicine. Discussions were led by William La Joie, M.D., and Robert McGovern, M.D.

Committee appointments for the year 1959 include: Dr. Nenad, Scientific Chairman; Dr. Gamble, Legislative Chairman; Dr. Shank, Public Information Chairman; Dr. Mason, Membership Chairman; Dr. Howard B. Seyfert, Vocational Guidance.

COLORADO

The Colorado Association of Chiropodists entertained at a testimonial dinner in Denver on January 10th honoring its five Life Members: Drs. Watson, Tecklenburg and Wallace of Denver; Dr. Nell D. Macy of Pueblo and Dr. Frank Silver of Boulder.

Special awards were presented to each of the honored guests.

ILLINOIS

Zone I

Zone I of the Illinois Chiropody Society held an election of officers at the regular

Awards for Research Papers

The Wm. J. Stickel Annual Awards
for Research in Chiropody (Podiatry) for 1959

Sponsored by the

Journal of the American Podiatry Association
and
The NAC Agency, Inc.

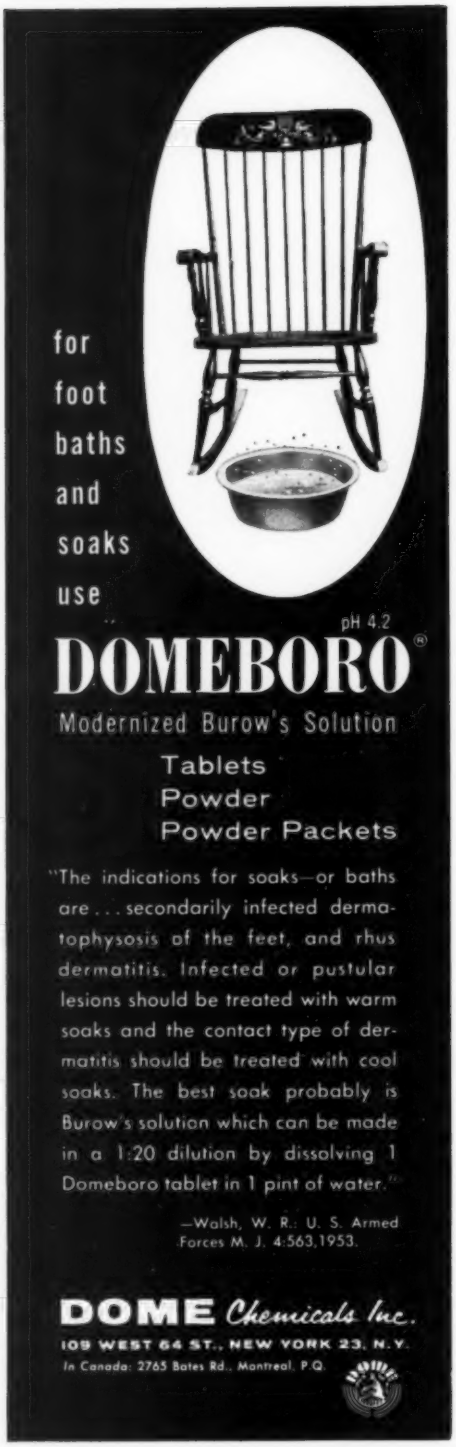
Fifteenth Year of Awards

1st Award - $400.00 — 2nd Award - $250.00 — 3rd Award - $100.00
4th and 5th Awards - each $50.00

THE DREW AWARDS

For research on the practical application of shoes to foot problems.
1st Award - $200.00 — 2nd Award - $150.00 — 3rd Award - $100.00

Application forms, rules and regulations can be obtained from the Secretary. The final date on which papers will be accepted is May 1, 1959.


for
foot
baths
and
soaks
use
pH 4.2
DOMEBORO®
Modernized Burow's Solution
Tablets
Powder
Powder Packets
"The indications for soaks—or baths are . . . secondarily infected dermatophysosis of the feet, and rhus dermatitis. Infected or pustular lesions should be treated with warm soaks and the contact type of dermatitis should be treated with cool soaks. The best soak probably is Burow's solution which can be made in a 1:20 dilution by dissolving 1 Domeboro tablet in 1 pint of water."
—Walsh, W. R.: U. S. Armed Forces M. J. 4:563,1953.
DOME Chemicals Inc.
109 WEST 64 ST., NEW YORK 23, N.Y.
In Canada: 2765 Bates Rd., Montreal, P.Q.

meeting on January 14, 1959. The following members were elected to office: President, Franklin A. Hines; Vice President, Einar D. Peterson; Secretary, Robert E. Merriman; Scientific Chairman, Chester J. Roth; Membership Chairman, Maurice Udall; Treasurer, Oscar C. Dahlgren; Senior Delegate, C. J. Roth; Junior Delegate, A. M. Ruff; Senior Alternate Delegate, Robert Roberts; Senior Alternate Delegate, E. D. Peterson; Proctoring Chairman, Reuben Goldstein; Sergeant-at-Arms, Willard Kapnick.

Zone III

The quarterly meeting of Zone III, Illinois Chiropody Society, was held Sunday, December 7, 1958, at the Jefferson Hotel, Peoria, Illinois. The business meeting was highlighted by the appearance of Miss Ann Fox, Executive Secretary of the Illinois Chiropody Society. Dr. Jack Stern, President of the Illinois Chiropody Society, spoke on "Practical Office Surgery" and "X-ray Technique and Interpretation." Following the meeting, a banquet was held in honor of George Guenzler, President of the American Podiatry Association and Zone III member of many years. Dr. Guenzler was presented with a gift from Zone III by Dr. George Geppner, President.

IOWA

At the annual meeting of the Iowa State Chiropody Association held in Des Moines on December 7 and 8, 1958, the following officers were elected: President, Dr. W. L. Franson; President-elect, Dr. C. A. Bartell; Secretary-Treasurer, Dr. Margaret F. Merrigan; Vice Presidents, Drs. R. E. Holdeman and J. W. Moore.

Chicago College of Chiropody

The Chicago College will hold a full day session on injections, injectables and injection therapy on Sunday, March 1, 1959. Sessions will include lectures on Practical Use of Syringes, Disposable Syringes, Sterilization of Needles and Syringes, Parenteral Drugs of Systemic and Local Action

used in Chiropody, Use of Ethyl Chloride, Joint Paracentesis, Injectables for Verrucae Therapy, Allergic Reactions to Parenteral Therapy. Lecturers will be Kurt L. Eichelbaum, M.D., Frederick B. Streiker, D.S.C., John B. Collet, D.S.C., Irving M Sward, D.S.C., Verne S. Hall, D.S.C., Jack Stern, D.S.C., and Alexander Salomon, M.D.

PENNSYLVANIA

Northwestern Division

A regular meeting of the Northwestern Division, Chiropody Society of Pennsylvania, was held Sunday, January 18, 1959, at Franklin. Report was made of the acceptance of Dr. T. P. Huels for affiliation with the Greenville Hospital. Communications were presented concerning the proposal by Northwestern Division of Life Membership in the Chiropody Society of Pennsylvania for Dr. Ralph Dye and Dr. Thomas Fletcher.

Dr. Roy Yorns, Scientific Chairman, introduced Dr. John McCandless of Franklin, who lectured and demonstrated plaster cast techniques for fracture.

LEGAL AND LEGISLATIVE

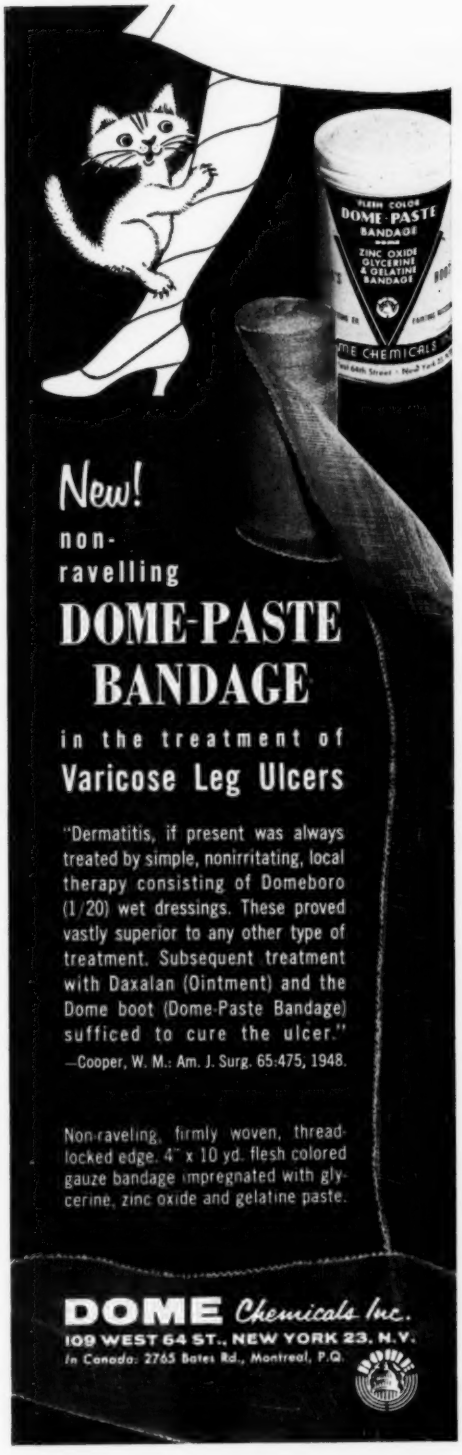
At the January meeting of the Connecticut Chiropody Society, Dr. Walker reported that the Connecticut Medical Service has agreed to recognize claims for services performed by podiatrists-chiropodists that are covered by the contracts. Participating practitioners are required to sign a Connecticut Medical Service contract.

DEATHS REPORTED

Mary McDermott
New York, N. Y.

Dr. McDermott, an active member of the Podiatry Society of the State of New York for more than 25 years, passed away on January 6th.

George Schroers
Paterson, N. J.
Lorraine Weitzel
Meadville, Pa.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in the treatment of
Varicose Leg Ulcers
"Dermatitis, if present was always treated by simple, nonirritating, local therapy consisting of Domeboro (1/20) wet dressings. These proved vastly superior to any other type of treatment. Subsequent treatment with Daxalan (Ointment) and the Dome boot (Dome-Paste Bandage) sufficed to cure the ulcer."
—Cooper, W. M.: Am. J. Surg. 65:475, 1948.
Non-raveling, firmly woven, thread-locked edge. 4" x 10 yd. flesh colored gauze bandage impregnated with glycerine, zinc oxide and gelatine paste.
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REPORT TO THE MEMBERSHIP

A report has been received from Secretary Rubin which states that the number of members who are delinquent (for nonpayment of dues), as of the start of this new year, stands at 515. This is an appalling number when you consider our total membership is less than ten times this amount. Pennsylvania has the dubious honor of having the greatest number who have not paid their dues. Steps have already been taken to correct this black mark and we trust the other states will immediately follow suit.

It is all very well to invite new members to join with us for the good of themselves and our profession, but if the members are not going to continue their membership, then our efforts are in vain. We are not a police state wherein you must join or you will not be permitted to practice. We firmly believe, however, that organized chiropody-podiatry is the only way we can accomplish our objectives and serve the public. Medicine and dentistry accomplished these objectives through organization and what better example could we emulate?

We have all seen the cartoon in which the two donkeys are tethered together but strain in opposite directions for food. They go hungry until they learn to work as a team. So it is with the profession of chiropody-podiatry. We may have our differences, even to the point of disagreement as to whether we are chiropodists or podiatrists, but basically we are foot doctors and by joining as such we can win success. The start of this togetherness is through membership and anyone who reneges on his dues is hurting all, including himself. Let's get those dues in—how can you lose? They are a deductible item and your insurance savings alone go a long way toward paying them.

This month we wish to extend congratulations to Dr. R. H. Lanhan, Membership Chairman of the Indiana State Podiatrists Association, and Dr. Ben L. Smith, Membership Chairman of the Chiropody Society

FOOT BALANCE INLAYS

are only completely
successful
when each case
is individually studied, diagnosed
and an inlay made to fit its
special requirements

The laboratory of

CARL G. BERGMANN, D.S.C.

5406 BROADWAY **CHICAGO 40, ILL.**

originator of foot balance inlays is directed
in all its endeavors to accomplish this result

of Texas, on the success of their state-wide membership campaigns. All membership committees are constantly working to increase membership, but a more concentrated effort on the part of each State Society Membership Committee can really pay off. States interested in conducting a membership campaign of this type can receive information on successful plans used by other membership committees by writing the State Society Membership Committee.

JOHN C. PANKRATZ, *D.S.C.*
Meadville, Pa.

COMMUNICATIONS FROM THE PROFESSION

To the Editor:

Recently there has been reference in the news and elsewhere to motivation research. I am especially interested in learning if our organization has considered commissioning a motivation research individual or firm to study the aversion people may have to foot care in general and the psychological acceptance or rejection to the terms podiatry-chiropody. It has been suggested to me by some of the psychologists with whom I work in the state institution that there is a reluctance on the part of people to accept foot health and this may be a cause for the difficulty some of our young men have in establishing successful practices.

I would like to suggest that very serious consideration be given to such a study. The cost is prohibitive for a small society to engage in this project and would have to be done on a national basis. Perhaps a graduate student working towards his Ph.D. would be interested in considering this field of study for his thesis. This could be a preliminary study which, if it pointed out the need for such a project, could then be attempted on a broader scale.

L. E. Krause, D.S.C.
Great Bend, Kansas

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POLYSORB HYDRATE, the balanced water-in-oil emulsion, *continuously* releases water, as needed, for essential tissue hydration. Bland, non-sensitizing, non-irritating POLYSORB HYDRATE also provides prolonged emollient and protective action for the deeper cells.

Available in 50 Gm. tubes, 425 Gm. jars. POLYSORB HYDRATE is a water-hydrated, specially processed, balanced emulsion system consisting of sorbitan sesquioleate and wax petrolatum. (Literature and sampling available on request.)

E. FOUGERA & CO., INC. **Hicksville, Long Island, New York**

To the Editor:

I made an error of fact in the closing paragraph of my article on "Negative Galvanic Current in the Surgical Correction of Onychocryptotic Nails," Journal, A.P.A., December 1958. First sentence of that paragraph reads: "The use of galvanic current for surgery is not new but was in little use in this region (Northern California) prior to 1956."

A communication was received as follows:

"We have had sine-galvanic machines in the clinics of the California College of Chiropody since the early '20's. . . . These modalities were very popular and were taught thoroughly until the '40's but as surgery and other modalities became popular, sine-galvanic lost its popularity.

"This nail technique was written up by Cordingly and others in the early Clinical Journals. It was done in this area."

I want to apologize to all the Northern Californians who have been familiar with and have been using this technique for years. My article recognized that it was not a new technique I was discussing, but rather to point up the revival in its use and some of the resultant experiences.

I am grateful and flattered that my article should have been read at the convention, printed in the Journal, and of sufficient interest to be read to its last paragraph.

PHILIP GARDNER, D.S.C.
Redwood City, Calif.

HOSPITAL SERVICE NEWS

GEORGETOWN UNIVERSITY

Dr. Jerome Shapiro has been appointed Assistant in Medicine by the Executive Faculty of the Georgetown University School of Medicine.

ST. LUKE'S AND CHILDREN'S MEDICAL CENTER

Post-Graduate Intern Training

In June 1956, Dr. James C. Giuffré, Medical Director of St. Luke's and Children's Medical Center, established the post-graduate podiatry-chiropody intern training program. The Department of Podiatry was established in September 1958.

The podiatry intern is required to be on

OUR NEWEST MOULD

The Levy Latex Mould and Contour Inlay made completely of Latex and Sponge Rubber.

After many years of intense research and the cooperation of a prominent Doctor and Competitor, we have at long last succeeded in fulfilling the idea originated by Dr. Ben Levy **TO CUSHION THE FOOT.**

This product constructed of Sponge and Latex Rubber is far superior in comfort to any so-called space shoe, and, very important to our woman to-day, in no way mars the beauty of the shoe.

We strongly recommend it for those suffering from Arthritis, Circulatory or Diabetic conditions. Also for bony, rigid and sensitive feet as well as for Verruca, Ulcers and Scar Tissues. It also is made in an inlay type without crest.

The **ORIGINAL CONTOUR** is retained at all times.

A negative or positive Cast at right angle is necessary.

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384 Columbus Ave., New York 24, N. Y.

call at least eight hours per day and is responsible for all clinical podiatry cases. He attends all staff resident lectures and assists in all foot surgical cases.

Clinical Service: The intern is required to attend all clinics of the hospital for the study of all foot pathologies and the pedal manifestations of systemic diseases. The following clinics are attended: allergy, dermatology, medical, metabolic and peripheral vascular, orthopedic, surgical and physical therapy. In these clinics the intern is able to observe and treat, under supervision, geriatric, pediatric, traumatic, post-traumatic and diagnostic foot pathologies. In addition to the above clinics, the intern is required to spend a set time in the accident ward and industrial clinic in order to study acute traumatic injuries of the feet and emergency treatment.

Podiatry and Ward Service: Under the supervision of the podiatry staff, the intern treats cases in the podiatry clinic. Ward rounds are made by the man on service.

Laboratory Service: The intern is required to spend a set time in the clinical laboratory in the following departments: hematology, chemistry, urinalysis, bacteriology, blood bank, mycology, serology, pathology and is required to attend the pathology lectures.

Radiology Service: The intern is required to spend a set time in the daily radiology readings where foot pathologies are demonstrated. The intern has access to all films in the x-ray department.

Operating Room: The intern is required to spend a set time in the operating room under the guidance of the surgical, orthopedic, podiatric and anesthetic departments. The intern has the opportunity of observing all surgical procedures and especially those related to the lower extremity.

At the present time, the length of time spent at St. Luke's has varied from four to twelve months, this time being dependent upon the number of interns at the University. Seven podiatrists have completed this program and two more have just started their tour of duty.

BENEFICIAL IN 84% OF 599 DERMATOLOGICAL CASES[1-4]

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WET DRESSINGS

Clinically proved PROPHYLLIN combines antipruritic, fungistatic sodium propionate with the healing properties of water-soluble chlorophyll derivatives. The result ". . . perhaps comes closer than any other agent to have all the qualities desired . . . in a wet dressing."[1]

PROPHYLLIN is helpful in acute inflammatory conditions such as contact dermatitis and dermatophytosis, and in infected wounds and ulcers. The chlorophyll derivatives in PROPHYLLIN increase the usual soothing effect of wet dressings and encourage healing. Mild antibacterial and fungistatic effects make PROPHYLLIN wet dressings and soaks unusually advantageous in cases which cannot tolerate other types of therapy.

Available in cartons of 12 single-dose packets and in 4-ounce and 16-ounce jars of bulk powder.

(1) Noojin, R. O. and others: Am. Pract. & Digest Treat. *5*:186, 1954. (2) Edelson, E.: Med. Times *82*:37, 1954. (3) Peck, S. M. and others: A.M.A. Arch. Dermat. & Syph. *67*:263, 1953. (4) Ignatoff, W. B.: J. New Jersey Chirop. Soc., Apr. 1953.

Rystan company

MOUNT VERNON, N. Y.

Please send me samples of Prophyllin Powder for preparation of wet dressings.

Dr. _____

_____

Dept. D 8-58

CONVENTION DATES AND MEETING NOTICES

American Podiatry Association
New York, N. Y., August 27-Sept. 1, 1959
Waldorf-Astoria Hotel
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Boston, Mass., Sept. 25-27, 1959
Sheraton Plaza Hotel
Dr. Francis B. Powers
19 Dale Ave., Gloucester, Mass.

Region Two
(New York)
New York, N. Y., Feb. 20-22, 1959
Barbizon Plaza Hotel
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Atlantic City, N. J., May 7-10, 1959
Ambassador Hotel
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four
(Ohio)
Columbus, Ohio, May 21-23, 1959
Deshler-Hilton Hotel
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Chicago, Ill., March 20-22, 1959
Morrison Hotel
Dr. Earl G. Kaplan
14608 Gratiot Ave., Detroit 5, Mich.

Region Six
(Colo. Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Kansas City, Kans., April 10-12, 1959
Town House Hotel
Dr. Reid L. Cox, Gen. Chairman
409 Huron Bldg., Kansas City, Kansas

Region Seven
(Idaho, Mont., Oreg., Wash., Wyo.)
Vancouver, B. C., Spring, 1959
Norm Matthews, D.S.C.
Suite 322, 604 Columbia St.,
New Westminster, B. C.

Region Eight
(D. C., N. C., S. C., Va., W. Va.)
Norfolk, Va., June 10-15, 1959
Aboard M. V. Arosa Sun
Dr. Irwin T. Domsky
2780 S. Randolph St., Arlington, Va.

Region Nine
(Florida)
Gainsville, Florida, May, 1959
Dr. Joy E. Adams
401 Florida Natl. Bank Bldg.,
St. Petersburg, Fla.

Region Ten
(Ala., Ga., Ken., Miss., Tenn.)
Louisville, Ky., Oct. 9-11, 1959
Brown Hotel
Dr. Chester A. Nava
4140 Shelbyville Rd., Louisville, Ky.

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Southwestern Chiropody Congress
Little Rock, Ark., June 17-20, 1959
Marion Hotel
Dr. W. C. Gigerich, Gen. Chairman
Arkansas Natl. Bank Bldg., Hot Springs, Ark.

Region Twelve
(Ariz., Cal., Nev., Utah)
Western Chiropody Congress
San Francisco, Calif., May 29-30, 1959
Mark Hopkins Hotel
Dr. Alfred G. Roos
209 Post St., #412, San Francisco 8, Calif.

American College of Foot Surgeons
Las Vegas, Nev., Feb. 16-18, 1959
Riviera Hotel

West Virginia State Convention
Charleston, West Va., May 15-17, 1959
Daniel Boone Hotel

Attend
Your State & Regional Meetings
Then Your
NATIONAL
House of Delegates, August 27, 28, 31, 1959
SCIENTIFIC SESSIONS, AUGUST 29, 30, 31, SEPTEMBER 1, 1959
WALDORF-ASTORIA HOTEL, NEW YORK, N. Y.

MOOD ELEVATORS

"Socrates was put to death by his own people for telling unkind truths, but Hitler was crowned by his for telling palatable lies."

Sidney J. Harris

The teacher looked sternly at young Jimmy. Someone told me you went to the movies yesterday and that's why you were not at school."

"That ain't so," was Jimmy's angry reply. "And I gotta fish to prove it."

I've got a date with your boss, dear. Don't be surprised if you get a raise next week.

Love & Hisses

"Well, Old Friend," said the Old Friend's friend, "that wasn't a very big account of your daughter's wedding in the paper."

"No," lamented Old Friend, "the big account was sent to me."

"Oh now, I wouldn't say they looked like gunboats, exactly!"

FOR THE FINEST IN LATEX SHIELDS

CUSTOM BUILT PROSTHETICS DESIGNED AND TAILORED
BY CHIROPODISTS FOR THE CHIROPODY PROFESSION
TO CASTS OR IMPRESSIONS

Hammer Toe

Bunion
and special types

Heloma Durum

LIQUID RUBBER APPLIANCE LABORATORY

NEW ADDRESS

45 Valley Way **West Orange, N. J.**

Prompt Service Send for brochure

Tit for Tat

The old sea captain was a stickler for keeping his log accurate and up to date. One day he wrote: "First mate drunk all day."

The F.M. blew up. "First and only time I was ever drunk," he expostulated.

"Is the entry true?" demanded the captain.

"Well, yes."

"Then let it stand," said the Old Man.

But soon it came the mate's duty to keep the log and he entered: "Captain sober all day."

This time the captain, a teetotalist, exploded.

"What do you mean by making such an entry?" he roared.

"Is the entry true?" asked the mate.

"Yes, but — "

"Then let it stand," said the mate and quickly walked away.

C. & O. Rwy. Tracks

"Well, I see that you oiled the drill again."

Anticipation

This was the capstone in a list of complaints, from a middle-aged patient of mine. "I'm really getting old, Doctor," he said. "My feet hurt now before I get out of bed!"

—M.F.H.
Modern Medicine

HAVE YOU SENT IN YOUR CONTRIBUTION AND/OR PLEDGE

Our goal is $100 from each member of the profession.

Enclosed is my contribution of $_____ to the Fund for the Advancement of Podiatry (Chiropody) Education.

I wish to ANNUALLY pledge $_____ to the Fund.

Bill me: Annually ( ) Semi-annually ( ) Quarterly ( )

I wish my donation designated for:

( ) The General Fund, for all schools.

( ) Earmarked for _____ Podiatry Chiropody College.

Name _____
PLEASE PRINT

Street Address _____

City _____ State _____

FUND FOR ADVANCEMENT OF PODIATRY-CHIROPODY EDUCATION

3301 16TH STREET, N. W.
WASHINGTON 10, D. C.

AS Hubby looked at the small piece of beef surrounding the big bone on his plate, he said to his Missus, "Darling, you sure are cutting expenses to the bone."

---

temperamental. Easy glum, easy glow.

Town Journal

Drive carefully, don't insist on your rites.

"He's a chiropodist, you know!"

Personnel manager to prospective employee, "Let's see now, Jones, you say here you were 23 years at your last place . . . why did you leave?"

Replied the prospective employee, "I was paroled."

One man says that since airlines will let customers pay for their trips in installments now we can all be debt-propelled.

Two things in life I've had and ample:
Good advice and bad example.

When the man was arrested for stealing an automobile the Judge told him he could be tried by him alone or by a jury of his peers. "What's peers?" was the suspicious question.

"That means your equals. People of your own kind."

"I'd rather you try me, Judge. I'm not trustin' no bunch of automobile thieves."

POST — TREATMENT

value of the Patient Education Pamphlet

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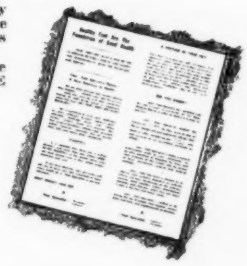

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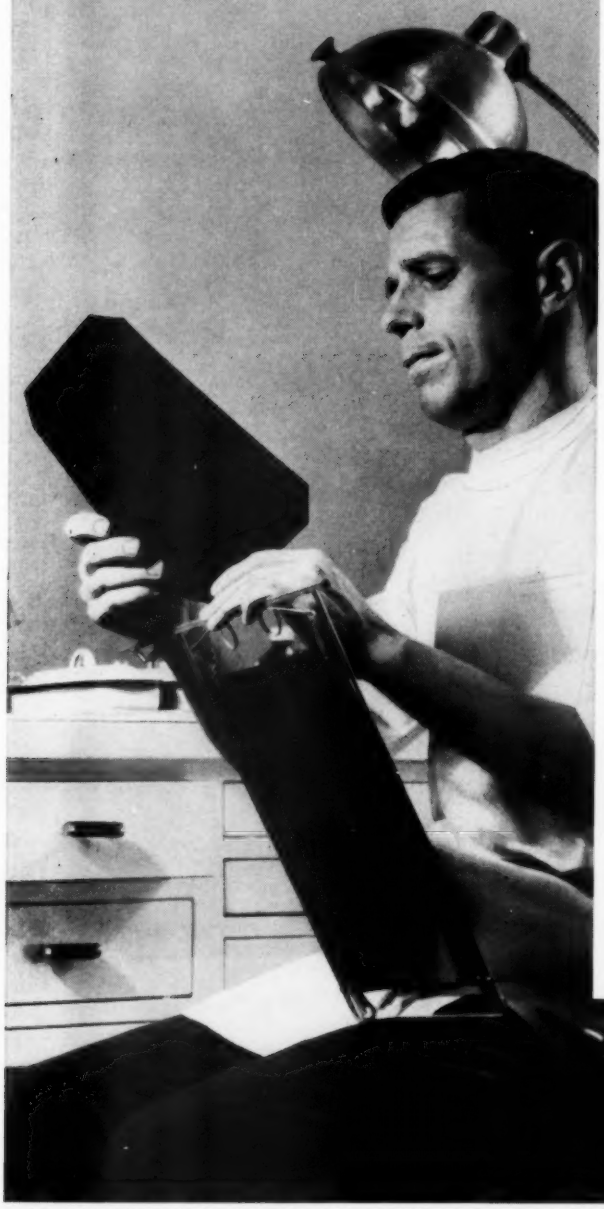

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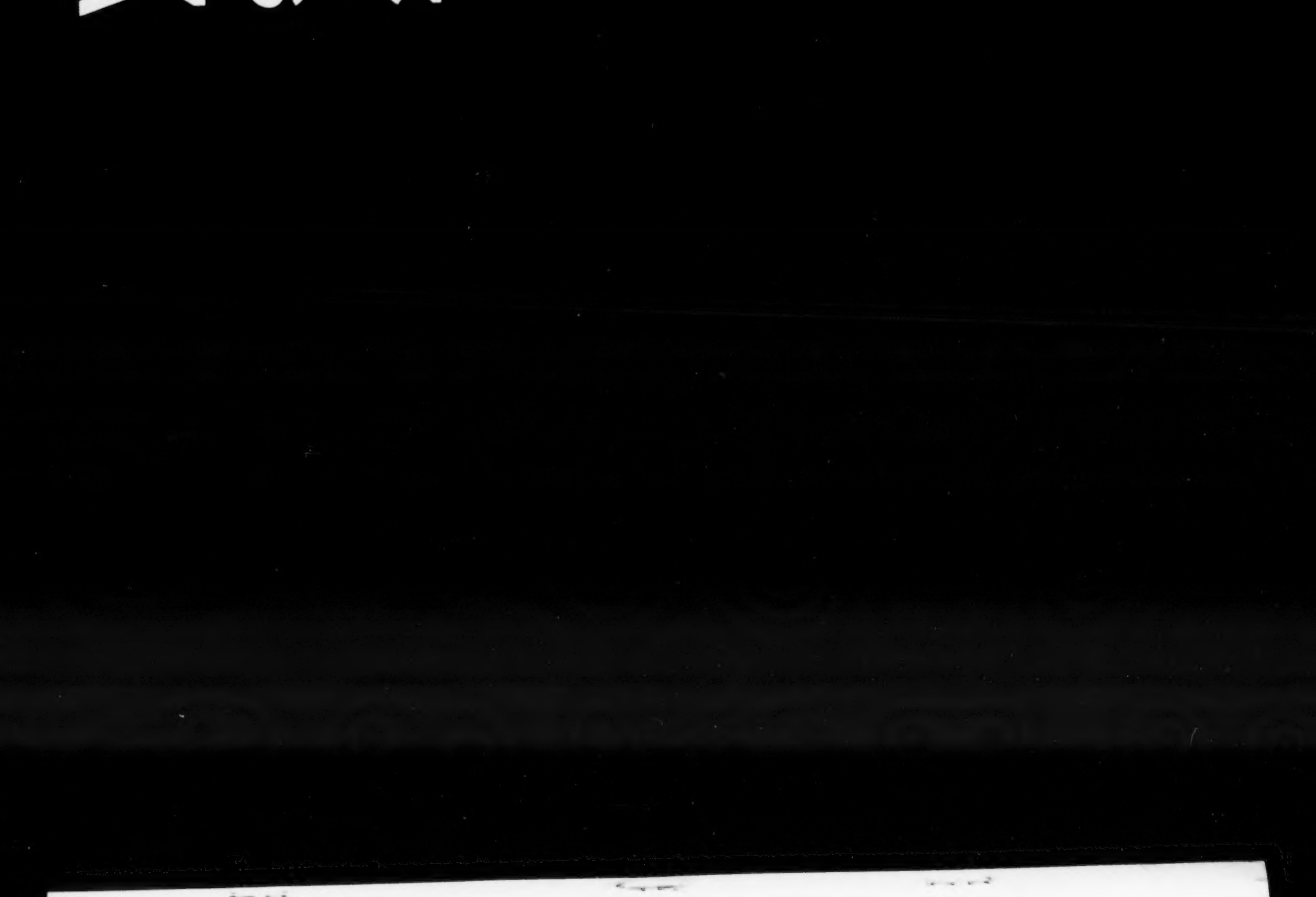
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